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# Autonomy and Death

Annette E. Clark\*

*In this Article, Professor Clark explores the contours of the current debate over physician-assisted death. She begins by focusing on the legal issues raised by statutory attempts to either legalize or criminalize physician-assisted death, with particular emphasis on the constitutional questions that are currently before the United States Supreme Court. She then examines physician-assisted death from both medical and societal perspectives. Professor Clark uses a thought experiment in which assisted death is facilitated by persons other than physicians, and in doing so, questions whether physicians are the proper persons in whom to rest power over assisted death. She points out the irony in a process that would set up physicians as protectors of individual autonomy, and ultimately concludes that by deferring to the medical profession in this process, we risk losing the very autonomy that assisted death is designed to effectuate.*

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\* Associate Professor, Seattle University School of Law. M.D. University of Washington School of Medicine, 1985; J.D. University of Puget Sound School of Law (now Seattle University), 1989.

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## I. INTRODUCTION

A physician writes a prescription for a lethal dose of pills with the knowledge that an individual intends to use the medication to end his or her own life.<sup>1</sup> Or, at the request of the individual, a physician intentionally causes the person's death by administering a lethal dose of a drug.<sup>2</sup> An extraordinary confluence of events—legal, medical, and ethical—has forced the issues of physician-assisted suicide and euthanasia to the forefront of the debate over individual autonomy and the power of the state to regulate individual decisionmaking.<sup>3</sup> In the past five years, opponents and proponents of legalization of euthanasia and physician-assisted suicide have advanced and retreated in waves, making their voices heard within the state legislative processes, through grassroots state initiatives, and more recently, through federal constitutional challenges. It now appears that the opposition is at an

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1. Physician-assisted suicide occurs when a physician writes a prescription for a lethal dose of pills or counsels the patient on doses and methods of administration with the knowledge that the patient intends to take his or her own life. See Peter A. Singer & Mark Siegler, *Euthanasia—A Critique*, 322 NEW ENG. J. MED. 1881, 1881 (1990); Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844, 848 (1989). Thus, the physician provides the means and guidance but the final act is performed by the patient. See Singer & Siegler, *supra* at 1881.

2. Voluntary euthanasia occurs when a physician administers a drug or other agent at the individual's request, thereby performing the final act that results in the patient's death. See David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1844 (1989); Singer & Siegler, *supra* note 1, at 1881 (defining euthanasia as "the deliberate action by a physician to terminate the life of a patient"). Literally, the term "euthanasia" means "good" or "gentle" death. Edmund D. Pellegrino, *Doctors Must Not Kill*, 3 J. CLINICAL ETHICS 95, 95 (1992). Of course, although this point is frequently ignored or forgotten, euthanasia can be performed by non-physicians.

3. In this sense, the debate over assisted suicide and euthanasia follows in the rather formidable footsteps of the abortion debate. The question of whether a state can constitutionally prohibit physician-assisted suicide for the terminally ill turns on an analysis of the Supreme Court's abortion jurisprudence. See discussion *infra* Part II.C; see also Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803 (1995) (discussing whether the abortion cases support a constitutional right to assisted suicide).

ebb and we will soon see the practice of legal physician-assisted suicide or euthanasia in one or more states.<sup>4</sup>

An interesting phenomenon has occurred in the ongoing debate over whether we, as a community, should move toward a society in which assisted death<sup>5</sup> is allowed and even facilitated. In virtually every proposal, initiative, constitutional challenge, and debate, a crucial and often implicit assumption has been made: if we legalize assisted death for the terminally ill, the medical profession, specifically physicians, will be the individuals empowered to assist or actually perform the acts that result in death.<sup>6</sup> It is almost as if legislators and commentators cannot imagine any other possibilities.<sup>7</sup>

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4. See Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 61-62 (1994) (stating that, given the current trend in public and professional opinion, voluntary euthanasia and assisted suicide will likely be legalized); *States Wrangle with Death Wishes*, USA TODAY, May 23, 1994, at 8A (quoting Arthur Caplan of the Center for Bioethics at the University of Pennsylvania as stating, "I expect to see a state in the next few years legalize [physician-assisted suicide]").

The citizens of Oregon in 1994 passed a ballot measure legalizing physician-assisted suicide under some circumstances, but the statute was struck down as unconstitutional. The case is currently on appeal to the Ninth Circuit. See *infra* Part II.B.2. In addition, the Washington and New York statutes that criminalize assisting suicide have been declared unconstitutional by the Ninth and Second Circuits respectively, to the extent that they prohibit physician-assisted suicide for the competent, terminally ill. See *infra* Parts II.C.2-3. If the United States Supreme Court affirms these decisions, we will see legalized assisted suicide in the near future.

Legalized physician-assisted death already occurs in Australia. In 1995, a regional parliament in Darwin, Australia passed a bill legalizing physician-assisted suicide and lethal injection for the terminally ill. See Philip Shenon, *Australian Doctors Get Right to Assist Suicide*, N.Y. TIMES, July 28, 1995, at A8; see also Tom Bates, *Australian Territory OKs Suicide Bill*, OREGONIAN, May 25, 1995, at A5. Any Australian who meets the statutory requirements may travel to the Northern Territory to take advantage of the statute's provisions. See *id.*

5. I have borrowed the term "assisted death" from an article by Howard Brody and will use it to include both assisted suicide and euthanasia. See Howard Brody, *Assisted Death—A Compassionate Response to Medical Failure*, 327 NEW ENG. J. MED. 1384 (1992).

6. When commentators do explicitly discuss physician involvement, it is usually in response to the broader substantive question of whether to permit or prohibit euthanasia and assisted suicide. Discussion of physician participation also comes up in process debates, but there the focus is on how to regulate physicians as opposed to whether they should be involved at all.

7. Occasionally the idea of assisted suicide or euthanasia performed by non-physicians is raised, but only as a scare tactic in the argument against assisted death rather than as a serious proposal. Consider, for example, the following language that appeared in an editorial piece in the *New York Times*:

Society finds terminal illness and terrible suffering a bitter pill to swallow. Some physicians, laymen, legislators, jurors and judges prefer to deal with that pill by sugarcoating it with the legal veneer of medical killing: somehow, it is

This, then, is an article about processes and possibilities. It challenges the notion that the only question to be answered is whether we should, as a legal, ethical, and moral matter, support some form of *physician-assisted suicide or euthanasia*.<sup>8</sup> It posits that the question whether physicians are the proper persons in whom to rest this power is equally important. And, in asking this question, it explores why we, as a society, are so intent on placing euthanasia and assisted suicide within the realm of medicine.

To this end, Part II sets the stage by describing the current climate for physician-assisted death in terms of public opinion and legal developments. Part III uses the medical literature and physician surveys as a means of discerning the medical profession's perspective on the proper role of the physician in these processes. Part IV then moves to a broader societal perspective on the physician's role through the use of a thought experiment in which assisted suicide and euthanasia are facilitated by individuals other than physicians. In the course of carrying out this thought experiment, I explore the irony of the current proposals that would set up physicians as protectors of individual autonomy in the medical decision-making process. The analysis then comes full circle by exploring how the contemporary societal desire to defer to the medical profession in this context informs the debate on the broader substantive question whether to legalize assisted death.

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easier if doctors rather than trained bureaucrats do the killing. Any non-physician could be trained to do what Dr. Kevorkian does, and society could decide that creating a suicide-assistance bureaucracy, without the benefit of the fig leaf of medical-based killing, would be an efficient way to contend with terminal suffering.

Walter Reich, *First, Do No Harm*, N.Y. TIMES, May 9, 1994, at A17. Reich is a physician and scholar with the Woodrow Wilson International Center for Scholars.

8. I do not intend by this Article to minimize the importance of the first question. However, it has already received considerable attention. See DANIEL CALLAHAN, *WHAT KIND OF LIFE: THE LIMITS OF MEDICAL PROGRESS* 221-49 (1990); RONALD DWORKIN, *LIFE'S DOMINION* 179-241 (1993); EUTHANASIA: *THE MORAL ISSUES* (Robert M. Baird & Stuart E. Rosenbaum eds., 1989); CARLOS F. GOMEZ, *REGULATING DEATH* (1991); *PHYSICIAN-ASSISTED DEATH* (James M. Humber et al. eds., 1994); TIMOTHY E. QUILL, *DEATH AND DIGNITY: MAKING CHOICES AND TAKING CHARGE* (1993); DAVID C. THOMASMA & GLENN C. GRABER, *EUTHANASIA: TOWARD AN ETHICAL SOCIAL POLICY* (1990); *VOLUNTARY EUTHANASIA* (A.B. Downing & Barbara Smoker eds., 1986); *Dying Well? A Colloquy on Euthanasia and Assisted Suicide*, 22 HASTINGS CENTER REP., Mar.-Apr. 1992, at 6-55. In contrast, the issue of physician involvement from a societal perspective has received little or no attention.

## II. THE CURRENT CLIMATE

### A. Public Opinion

Jack Kevorkian. One need only utter the name to invoke a response. Depending on whom you ask, he is either an "angel of mercy" or "Dr. Death." His exploits have generated newspaper headlines over the past four years that would do justice to a supermarket tabloid. In fact, these headlines provide a very useful chronology of his activities, beginning in 1990 with Janet Adkin's death in the back of Kevorkian's van, and continuing to the present day.<sup>9</sup> The current count stands at forty-four Kevorkian-assisted deaths with no end in sight.

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9. The following *New York Times* headlines are arranged in chronological order and are divided into groups by the year in which they appeared.

1990: Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES, June 6, 1990, at A1; Isabel Wilkerson, *Physician Fulfills a Goal: Aiding a Person in Suicide*, N.Y. TIMES, June 7, 1990, at D22; Isabel Wilkerson, *Inventor of Suicide Machine Arrested on Murder Charge*, N.Y. TIMES, Dec. 4, 1990, at A1; Tamar Lewin, *Doctor Cleared of Murdering Woman with Suicide Machine*, N.Y. TIMES, Dec. 14, 1990, at B6; William E. Schmidt, *Prosecutors Drop Criminal Case Against Doctor Involved in Suicide*, N.Y. TIMES, Dec. 15, 1990, at 10. (Hereinafter any *New York Times* article that does not have a letter designating the section in which the article may be found is contained in the Late Evening Edition of that newspaper).

1991: Isabel Wilkerson, *Prosecutors Seek to Ban Doctor's Suicide Device*, N.Y. TIMES, Jan. 5, 1991, at 6; *Michigan Court Bars Doctor from Using His Suicide Machine*, N.Y. TIMES, Feb. 6, 1991, at A13; *Doctor Assists in Two More Suicides in Michigan*, N.Y. TIMES, Oct. 24, 1991, at A1; Isabel Wilkerson, *Opponents Weigh Action Against Doctor Who Aided Suicides*, N.Y. TIMES, Oct. 25, 1991, at A10; *Judge Says Suicide Doctor Does a 'Service,'* N.Y. TIMES, Oct. 27, 1991, at 21; *Doctor in Suicides Assails U.S. Ethics*, N.Y. TIMES, Nov. 3, 1991, at 30; *Michigan Board Suspends License of Doctor Who Aided in Suicides*, N.Y. TIMES, Nov. 21, 1991 at D22; *Prosecutor Seeks Murder Charges Against Doctor*, N.Y. TIMES, Dec. 20, 1991, at A18.

1992: *Suicide Device Inventor Charged with Murder*, N.Y. TIMES, Feb. 6, 1992, at A21; *Inventor of Suicide Machine Tied to Death of Dentist in California*, N.Y. TIMES, Feb. 13, 1992, at B14; *Ruling Favors Doctor Who Aided in Suicides*, N.Y. TIMES, Feb. 18, 1992, at A20; *Doctor Faces Murder Trial for Suicide Aid*, N.Y. TIMES, Feb. 29, 1992, at 10; *Michigan Doctor at Side of 4th Suicide*, N.Y. TIMES, May 16, 1992, at 6; *Kevorkian Provided the Gas for Woman's Suicide*, N.Y. TIMES, May 17, 1992, at 21; *Death at Kevorkian's Side Is Ruled Homicide*, N.Y. TIMES, June 6, 1992, at 10; *Murder Charges Against Kevorkian Are Dismissed*, N.Y. TIMES, July 22, 1992, at A12; *Doctor Assists in Another Suicide*, N.Y. TIMES, Sept. 27, 1992, at 32; *Doctor in Michigan Helps a 6th Person to Commit Suicide*, N.Y. TIMES, Nov. 24, 1992, at A10; Isabel Wilkerson, *Michigan Moves to Ban Doctors' Aiding in Suicides*, N.Y. TIMES, Nov. 25, 1992, at A14; *2 Commit Suicide, Aided by Michigan Doctor*, N.Y. TIMES, Dec. 16, 1992, at A21.

1993: *Kevorkian Aids Ninth Suicide*, N.Y. TIMES, Jan. 21, 1993, at A21; *Kevorkian Aids 2 More in Committing Suicide*, N.Y. TIMES, Feb. 5, 1993, at A15; *Kevorkian Assists Patient, 3d in Week, Commit Suicide*, N.Y. TIMES, Feb. 9, 1993, at A9; *Kevorkian Assists a Suicide for Fourth Time This Month*, N.Y. TIMES, Feb. 16, 1993, at A12; *Kevorkian Aids in 2 More Suicides; Total Is at 15*, N.Y. TIMES, Feb. 19, 1993, at A10; *Kevorkian-Aided*

*Suicide Investigated as Homicide*, N.Y. TIMES, Feb. 26, 1993, at A10; *New Inquiry Puts Pressure on Kevorkian*, N.Y. TIMES, Feb. 27, 1993, at 9; *Prosecutor Says He Won't Charge Kevorkian Now but Seeks Inquest*, N.Y. TIMES, Mar. 6, 1993, at 9; *Doctor Who Aided Suicides Loses License in California*, N.Y. TIMES, Apr. 28, 1993, at A13; Isabel Wilkerson, *Suicide Doctor Tests Law, Stays with Man Who Dies*, N.Y. TIMES, May 17, 1993, at A12; Isabel Wilkerson, *Kevorkian's Role in Latest Death Confounds Experts in Michigan*, N.Y. TIMES, May 18, 1993, at A17; Don Terry, *Kevorkian Assists in Death of His 17th Suicide Patient*, N.Y. TIMES, Aug. 5, 1993, at A14; *Kevorkian Details His Role in Suicide*, N.Y. TIMES, Aug. 7, 1993, at 28; *Kevorkian Said to Face Charge*, N.Y. TIMES, Aug. 17, 1993, at A12; Don Terry, *As He Hoped, Kevorkian Is Charged in a Suicide*, N.Y. TIMES, Aug. 18, 1993, at A12; *Kevorkian Asks Judge to Dismiss a Charge of Assisting in a Suicide*, N.Y. TIMES, Aug. 28, 1993, at 7; *Kevorkian, Ordered to Trial, Aids in a Suicide*, N.Y. TIMES, Sept. 10, 1993, at A16; *Kevorkian Charged a 2d Time Under Suicide Law*, N.Y. TIMES, Sept. 15, 1993, at A20; *Suicide Doctor Gets a Trial Date, and a Warning*, N.Y. TIMES, Sept. 25, 1993, at 10; *Kevorkian Is Facing 2d Trial*, N.Y. TIMES, Oct. 12, 1993, at A21; *Kevorkian, Pushing for Jail, Aids in Suicide in His Home*, N.Y. TIMES, Oct. 23, 1993, at 8; *Kevorkian Still Free on Bond After Attending 19th Suicide*, N.Y. TIMES, Oct. 24, 1993, at 14; *Suicide Doctor Is Jailed in Detroit Amid a Threat to Starve Himself*, N.Y. TIMES, Nov. 6, 1993, at 8; *After 3 Years of Assisting in Suicide, Kevorkian Lands in Jail*, N.Y. TIMES, Nov. 6, 1993, at 1; *Kevorkian Leaves Jail After 3 Days*, N.Y. TIMES, Nov. 9, 1993, at A15; Don Terry, *While Out on Bail, Kevorkian Attends a Doctor's Suicide*, N.Y. TIMES, Nov. 23, 1993, at A1; *Evidence Is Reported on Suicide Assistance*, N.Y. TIMES, Nov. 26, 1993, at A31; *Kevorkian Is Charged Again with Aiding a Suicide*, N.Y. TIMES, Nov. 30, 1993, at A18; *Kevorkian Returns to Jail, Refusing to Pay His Bond*, N.Y. TIMES, Dec. 1, 1993, at B10; *Weak but Defiant, Kevorkian Continues Jailhouse Hunger Strike*, N.Y. TIMES, Dec. 8, 1993, at B6; *Weakened by Fast, Doctor Appears in Court*, N.Y. TIMES, Dec. 11, 1993, at 11; *Kevorkian Is Taken to Emergency Room with Pains in Chest*, N.Y. TIMES, Dec. 13, 1993, at B8; *Suicide Law Struck Down, but Kevorkian Stays Jailed*, N.Y. TIMES, Dec. 14, 1993, at A18; *Clarifying Decision, Judge Voids All of Suicide Law*, N.Y. TIMES, Dec. 15, 1993, at A24; *Kevorkian Is Freed After Pledging to Refrain from Aiding Suicides*, N.Y. TIMES, Dec. 18, 1993, at 8; Jack Lessenberry, *In Tactical Change, Kevorkian Promises to Halt Suicide Aid*, N.Y. TIMES, Dec. 26, 1993, at 1.

1994: *Kevorkian Ordered to Stand Trial*, N.Y. TIMES, Jan. 6, 1994, at A16; *Court Hears Arguments on Assisted Suicide Ban*, N.Y. TIMES, Jan. 7, 1994, at A16; *Aided-Suicide Law Invalidated Again*, N.Y. TIMES, Jan. 28, 1994, at A17; *Kevorkian Begins Ballot Drive For Suicide Measure*, N.Y. TIMES, Jan. 31, 1994, at A13; *Trial Is Ordered for Suicide Doctor*, N.Y. TIMES, Feb. 19, 1994, at 9; *Suicide Law Still in the Dock as Kevorkian's Trial Nears*, N.Y. TIMES, Apr. 4, 1994, at B11; *Suicide Trial Set to Begin on Tuesday*, N.Y. TIMES, Apr. 17, 1994, at 23; *Using Surprise Strategy, Kevorkian's Lawyers Seek Acquittal*, N.Y. TIMES, Apr. 22, 1994, at A19; *Judge Rejects Motion to End Suicide Trial*, N.Y. TIMES, Apr. 26, 1994, at A21; *Kevorkian Takes Stand in Own Defense*, N.Y. TIMES, Apr. 28, 1994, at A16; Tamar Lewin, *Kevorkian Jury, Deliberating, Seems to Focus on Site of a Suicide*, N.Y. TIMES, Apr. 30, 1994, at 8; David Margolick, *Jury Acquits Dr. Kevorkian of Illegally Aiding a Suicide*, N.Y. TIMES, May 3, 1994, at A1; *Michigan Court Invalidates Law Banning Aid for Suicide*, N.Y. TIMES, May 11, 1994, at A22; *Kevorkian's Ballot Drive on Suicide Aid Stumbles*, N.Y. TIMES, July 6, 1994, at A14; *Michigan's High Court Hears Arguments on Assisted Suicide*, N.Y. TIMES, Oct. 5, 1994, at A21; Jack Lessenberry, *Kevorkian Helps in a Suicide as Ban Expires*, N.Y. TIMES, Nov. 27, 1994, at 28; *Kevorkian Challenges the Motives of 2 Doctors Who Offered to Intervene with His Patient*, N.Y. TIMES, Nov. 29, 1994, at B12; *New Suicide-Assistance Ban Gains in Michigan*, N.Y. TIMES, Dec. 8, 1994, at A26; *Michigan Suicide Bill Advances*, N.Y. TIMES, Dec. 14, 1994, at A18; *Kevorkian Vows to Keep Fighting Laws Barring Assisted Suicide*, N.Y. TIMES, Dec. 18, 1994, at 43.

1995: *Kevorkian Cases Dropped*, N.Y. TIMES, Jan. 15, 1995, at 17; *Linda Greenhouse, Court Won't Hear Appeal in Case of Assisted Suicide*, N.Y. TIMES, Apr. 25, 1995, at A17; *James Bennet, Dr. Kevorkian Assists at His 22d Suicide*, N.Y. TIMES, May 9, 1995, at A20; *Kevorkian Once Again Aids Suicide*, N.Y. TIMES, May 13, 1995, at 6; *Angry Michigan Court Upholds Injunction Against Kevorkian*, N.Y. TIMES, May 15, 1995, at A14; *Iver Peterson, In One Doctor's Way of Life, a Way of Death*, N.Y. TIMES, May 21, 1995, at 14; *Woman Dies at Kevorkian Clinic*, N.Y. TIMES, June 27, 1995, at A12; *Suicide Clinic Unwelcomed*, N.Y. TIMES, June 28, 1995, at A12; *In Assisted Suicide, Body Is Left Near Hospital*, N.Y. TIMES, Aug. 22, 1995, at A13; *Doctor Seeks to Quash Case of Murder in Suicide Deaths*, N.Y. TIMES, Aug. 30, 1995, at A12; *Murder Charges Against Kevorkian in 1991 Case Are Dismissed*, N.Y. TIMES, Aug. 31, 1995, at A21; *Kevorkian Faces Trial on Suicide Charges*, N.Y. TIMES, Sept. 1, 1995, at A12; *Body in Auto Is Reported to Be Kevorkian's 26th Assisted Suicide*, N.Y. TIMES, Nov. 9, 1995, at A17; *After Kevorkian-Aided Suicide, Clash over How Ill Woman Was*, N.Y. TIMES, Nov. 10, 1995, at A20; *Jack Lessenberry, Dr. Kevorkian Resumes Use of Machine*, N.Y. TIMES, Nov. 12, 1995, at 25; *Cancer Finding in Suicide Case of Kevorkian*, N.Y. TIMES, Nov. 19, 1995, at 35; *Doctors Offer Some Support to Kevorkian*, N.Y. TIMES, Dec. 5, 1995, at A21.

1996: *Kevorkian Attends Another Death; Woman's Body Is Left in Van*, N.Y. TIMES, Jan. 30, 1996, at A11; *Kevorkian and the Issue of Assisted Suicide Will Go on Trial for Second Time*, N.Y. TIMES, Feb. 12, 1996, at A10; *2 Views of Kevorkian: Killer or Comforter*, N.Y. TIMES, Feb. 21, 1996, at A16; *Testimony Continues at the Kevorkian Trial*, N.Y. TIMES, Feb. 23, 1996, at A14; *Kevorkian Jury Watches Tape of Patient Who Chose Suicide*, N.Y. TIMES, Feb. 25, 1996, at 28; *Kevorkian, Exploiting Exemption in Suicide Law, Testifies on the Pain That His Efforts End*, N.Y. TIMES, Mar. 2, 1996, at 20; *Kevorkian Says He Aims to Ease Suffering, Not to Hasten Death*, N.Y. TIMES, Mar. 6, 1996, at A19; *Jack Lessenberry, Kevorkian Again Not Guilty of Aiding Suicide*, N.Y. TIMES, Mar. 9, 1996, at 7; *Jack Lessenberry, After Victory, a New Trial for a Weary Kevorkian*, N.Y. TIMES, Mar. 11, 1996, at A13; *Kevorkian Going on Trial for 4th Time in Suicides*, N.Y. TIMES, Mar. 31, 1996, at 29; *Prosecutors Are Ordered to Show Kevorkian's Intent Was to Kill*, N.Y. TIMES, Apr. 7, 1996, at 14; *Kevorkian Faces Suicide Prosecution Without a Law Being Cited*, N.Y. TIMES, Apr. 17, 1996, at A20; *Kevorkian Is Excused from Attending Trial*, N.Y. TIMES, Apr. 19, 1996, at A26; *Jack Lessenberry, Specialist Testifies Depression Was Issue in Kevorkian Cases*, N.Y. TIMES, Apr. 24, 1996, at A17; *Trial Turns to Statements About Death on Videotape*, N.Y. TIMES, Apr. 28, 1996, at 21; *Jack Lessenberry, In Latest Suicide Trial, Kevorkian Asserts 'Duty as a Doctor'*, N.Y. TIMES, May 4, 1996, at 10; *Appeals Set Kevorkian Back Repeatedly*, N.Y. TIMES, May 5, 1996, at 27; *Jack Lessenberry, Dr. Kevorkian Says His Trial Is a Lynching*, N.Y. TIMES, May 7, 1996, at A15; *Despite Trial, Kevorkian Is at a Suicide*, May 8, 1996, at A20; *Clyde H. Farnsworth, Tape Recalls a Canadian's Gratitude to Kevorkian*, N.Y. TIMES, May 9, 1996, at A17; *Kevorkian Back at Trial as Talk of Detroit Is of Another Suicide*, N.Y. TIMES, May 10, 1996, at A16; *Jack Lessenberry, Once Again, Jurors Weigh Kevorkian's Fate*, N.Y. TIMES, May 11, 1996, at 20; *Caryn James, Dr. Kevorkian on Trial, with Hints of the Future*, N.Y. TIMES, May 14, 1996, at C18; *Jack Lessenberry, Jury Acquits Kevorkian in Common-Law Case*, N.Y. TIMES, May 15, 1996, at A14; *Kevorkian Assists Woman from New Jersey in Dying*, N.Y. TIMES, June 12, 1996, at A20; *Man Ordered to Live with Wife Who Had Consulted Kevorkian*, N.Y. TIMES, June 12, 1996, at A20; *Dr. Kevorkian Helps in Woman's Suicide, 3d Case in 9 Days*, N.Y. TIMES, June 21, 1996, at A18; *An Ailing Woman Kills Herself with Help from Dr. Kevorkian*, N.Y. TIMES, June 22, 1996, at 20; *Prosecutor of Kevorkian Loses Re-election Bid*, N.Y. TIMES, Aug. 8, 1996, at A23; *Jack Lessenberry, New Assistant to Kevorkian Is an Old Hand at Suicides*, N.Y. TIMES, Aug. 11, 1996, at 22; *Jack Lessenberry, Kevorkian Goes from Making Waves to Barely a Ripple*, N.Y. TIMES, Aug. 17, 1996, at 6; *Question of Family Violence Arises in a Kevorkian Suicide Case*, N.Y. TIMES, Aug. 18, 1996, at 25; *Clash in Detroit over How Ill a Kevorkian Client Really Was*, N.Y. TIMES, Aug. 20, 1996, at A13;



No matter what opinion one holds of Kevorkian as a person, there is no question that his actions, more than those of any other, have forced the issues surrounding assisted suicide and euthanasia into the public arena.<sup>10</sup> The result is an increasingly polarized debate, presented by proponents in terms of an individual's right to personal autonomy at the end of life, and by opponents in terms of society's interest in preserving and protecting life and preventing the abuses that would inevitably accompany such practices.

While Kevorkian has effectively brought the issue of assisted death into the public arena, society's awareness is founded on more than the activities of one physician. The surprising success of Derek Humphry's best-selling book *Final Exit*<sup>11</sup> suggests a tremendous reservoir of public interest in the concept of death and assisted suicide. That interest has been fed in recent years by a steady stream of media attention directed at, among other things, state legislative and constitutional attempts to legalize assisted death,<sup>12</sup> the Dutch policy of refraining from prosecuting physicians who perform assisted suicide and euthanasia,<sup>13</sup> a decision by the Supreme Court of Canada

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*Kevorkian Held Briefly after 2d Suicide in Day*, N.Y. TIMES, Aug. 23, 1996, at A15; Timothy E. Quill & Betty Rollin, *Dr. Kevorkian Runs Wild*, N.Y. TIMES, Aug. 29, 1996, at A25; Jack Lessenberry, *Police Break in on Patients Meeting with Kevorkian for an Assisted Suicide*, N.Y. TIMES, Sept. 7, 1996, at 8; Jack Lessenberry, *Kevorkian Helps 40th Suicide, Day After Police Tried to Intervene*, N.Y. TIMES, Sept. 8, 1996, at 38; Jack Lessenberry, *Video May Lead to a Case Against Kevorkian*, N.Y. TIMES, Sept. 21, 1996, at 6; *Kevorkian Aids 41st Death*, N.Y. TIMES, Sept. 30, 1996, at A15; *Another Body Left at Hospital by Kevorkian*, N.Y. TIMES, Oct. 18, 1996, at A22; *Kevorkian Assists in 44th Suicide Case*, N.Y. TIMES, Oct. 25, 1996, at A26.

10. See Lawrence K. Altman, *The Doctor's World: Use of Suicide Device Sets in Motion Debate on a Disturbing Issue*, N.Y. TIMES, June 12, 1990, at C3.

11. *Final Exit* is a poorly written and rather macabre manual designed to instruct dying individuals in the various methods of committing or assisting in suicide. See DEREK HUMPHRY, *FINAL EXIT* (1991). Derek Humphry's method of choice is a combination of lethal doses of drugs and asphyxiation by use of a plastic bag. See *id.* at 95-99. The book generated controversy from the very beginning, see Meg Cox, *Suicide Manual for Terminally Ill Stirs Heated Debate*, WALL ST. J., July 12, 1991, at B1, but a study linking the book's publication with an increase in suicide by asphyxiation in New York City fanned the flames of the debate. See Peter M. Marzuk et al., *Increase in Suicide by Asphyxiation in New York City after the Publication of Final Exit*, 329 NEW ENG. J. MED. 1508 (1993); Elisabeth Rosenthal, *Methods Used in Suicide Follow Book*, N.Y. TIMES, Nov. 6, 1993, at 25.

12. See *infra* Part II.B-C.

13. Although assisted suicide and euthanasia are still technically illegal under Dutch law, a 1993 statute codified an exemption from prosecution for physicians who follow strict medical and ethical rules in assisting their terminally ill patients to die. See Marlise Simons, *Dutch Move to Enact Law Making Euthanasia Easier*, N.Y. TIMES, Feb. 9, 1993, at A1; Marlise Simons, *Dutch Parliament Approves Law Permitting Euthanasia*, N.Y. TIMES, Feb. 10, 1993, at A10. In order to avoid prosecution under Dutch law, the doctor must ensure

upholding a ban on assisted suicide,<sup>14</sup> and the vote by an Australian territory to legalize physician-assisted death.<sup>15</sup> Media attention has taken a more personal turn as well. It is not uncommon these days to read narratives of the lives of the terminally ill and their struggles to achieve dignified deaths, with physicians' help or without.<sup>16</sup> A number of these stories are those of individuals dying from AIDS, who are increasingly turning to assisted suicide as a way to assert control over the relentless process of the disease.<sup>17</sup> Even the unassisted deaths of former President Richard Nixon and former First Lady Jacqueline Kennedy Onassis have been touted in the press as examples of

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that the request is voluntary and not coerced; the patient is experiencing intolerable suffering, has no hope of recovery, and has made repeated requests for euthanasia over a period of time; the individual is competent and well-informed at the time the aid is given; and another physician has been consulted. *See id.*

In two recent highly publicized cases, Dutch physicians provided assisted death in circumstances that fell outside the statutory guidelines. A psychiatrist gave a fatal dose of sleeping pills to a physically healthy but severely depressed woman who wished to kill herself. In a landmark ruling, the Netherlands Supreme Court held that the physician would not be punished even though his actions fell well outside the legal guidelines. *See Doctor Unpunished for Dutch Suicide*, N.Y. TIMES, June 22, 1994, at A10. In the other case, two Dutch doctors face criminal prosecutions for having euthanized two severely disabled newborns. *See Dutch Bring a Test Case in Euthanasia*, N.Y. TIMES, Dec. 23, 1994, at A3. The Royal Dutch Medical Association has now proposed changes in the guidelines, calling for physicians to use physician-assisted suicide instead of euthanasia when at all possible, emphasizing the need for consultation with an independent physician, and reaffirming the right of physicians who are morally opposed to euthanasia to refuse to assist. *See Marlise Simons, Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. TIMES, Sept. 11, 1995, at A3.

14. In that case, Sue Rodriguez, an individual suffering from amyotrophic lateral sclerosis (Lou Gehrig's disease), challenged the Canadian ban on assisted suicide. *See Clyde H. Farnsworth, Woman Who Lost Right-to-Die Case in Canada Commits Suicide*, N.Y. TIMES, Feb. 15, 1994, at B13. The Supreme Court of Canada, in a 5-4 decision, ruled that the government's interest in protecting life's sanctity took precedence over an individual's right to a dignified death. *See id.* Ms. Rodriguez committed physician-assisted suicide four months after the Court's ruling. *See id.*

15. *See Shenon, supra* note 4, at A8; *see generally* Christopher J. Ryan & Miranda Kaye, *Euthanasia in Australia—The Northern Territory Rights of the Terminally Ill Act*, 334 NEW ENG. J. MED. 326 (1996).

16. *See* David M. Eddy, *A Conversation with My Mother*, 272 JAMA 179 (1994); Dudley Clendinen, *When Death Is a Blessing and Life Is Not*, N.Y. TIMES, Feb. 5, 1996, at A15; Dick Lehr, *Death and the Doctor's Hand* (Part I), BOSTON GLOBE, Apr. 25, 1993, at 1; Dick Lehr, *Death and the Doctor's Hand* (Part II), BOSTON GLOBE, Apr. 26, 1993, at 1; Dick Lehr, *Death and the Doctor's Hand* (Part III), BOSTON GLOBE, Apr. 27, 1993, at 1; Andrew Solomon, *A Death of One's Own*, NEW YORKER, May 22, 1995, at 54.

17. *See* Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. TIMES, June 14, 1994, at C12; Gina Kolata, *AIDS Patients Seek Solace in Suicide, but Many Find Risk Added Pain in Failure*, N.Y. TIMES, June 14, 1994, at C1.

orchestrating death with dignity.<sup>18</sup> To the extent that the media expresses the realities of contemporary life, it is clear that many individuals are struggling with the profound issues related to death and dying.

In order to assess the range of societal beliefs and values on the specific topics of assisted suicide and euthanasia, three researchers performed a landmark study in which they analyzed the results of public opinion polls taken over the last forty years.<sup>19</sup> The study revealed a significant shift in public attitudes on the issues of assisted suicide and euthanasia. In 1950, only thirty-four percent of respondents answered affirmatively the question, "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life if the patient and his or her family request it?"<sup>20</sup> By 1977, this number had increased to sixty percent and has remained relatively stable ever since.<sup>21</sup> A 1991 *Globe/Harvard* poll confirmed the current consensus, with sixty-four percent of respondents agreeing that physicians should be allowed by law to respond to a terminally ill patient's request for lethal drugs or injections.<sup>22</sup> These study results suggest, somewhat surprisingly, that the shift in public opinion actually occurred years before the current debate over Kevorkian and legislative attempts to criminalize or legalize these practices.

The *Globe/Harvard* poll also went beyond the public-policy perspective to explore the personal dimension of beliefs on this subject. When asked what they would do if they themselves were terminally ill and in great physical pain, twenty percent of respondents

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18. See Janny Scott, *An Onassis Legacy: Facing Death on One's Own Terms*, N.Y. TIMES, June 4, 1994, at 1.

19. See Robert J. Blendon et al., *Should Physicians Aid Their Patients in Dying?*, 267 JAMA 2658 (1992). The researchers used a 1991 national opinion poll conducted by *The Boston Globe* and the Harvard School of Public Health to assess current opinion. See *id.* at 2658. To obtain information on how these attitudes and opinions have changed over time, they compiled and analyzed data from surveys conducted by various polling organizations between 1950 and 1991. See *id.*

20. *Id.* at 2659 fig. 1.

21. See *id.* Age seemed to play a significant role in these results. For example, 79% of respondents in the 18- to 34-year-old group believed a physician should be able to administer lethal drugs at a terminally ill individual's request, as compared to 53% of respondents aged fifty years and older. See *id.* Significant differences were seen across racial groups as well. From 1977 to 1989, whites were more likely than African Americans to support legislation legalizing assisted suicide and euthanasia by an average margin of 20%. See *id.*

22. See *id.* In sharp contrast, only 37% responded that it should be legal for a relative or close friend to assist. See *id.*

said they would ask their physician to administer a lethal drug, while nineteen percent said they would ask their physician to prescribe lethal drugs that they could take themselves.<sup>23</sup> Thus, a much smaller percentage of individuals believe they would actually turn to euthanasia or assisted suicide services than support their legalization. Only eleven percent of respondents would consider asking family or friends to help end their lives under these circumstances.<sup>24</sup> Interestingly, a full seventy-two percent would refuse to assist friends or relatives if asked to do so, with the result that "[t]he burden to act in such cases will ultimately rest with the attending physician."<sup>25</sup> The authors of the 1992 study concluded their report by predicting that, given the significant level of support for some form of legalized euthanasia, efforts to change public policy through legislation would continue and perhaps escalate.<sup>26</sup> They were right.

### B. *Legalizing Physician-Assisted Death*

With the significant public support expressed for physician-assisted death for the terminally ill and suffering, one would expect that the legal efforts in this country to codify such processes into law would have met with more success than they have thus far. That various attempts have been defeated or put on hold pending further legal challenge is more a reflection of the political process than a public mandate against assisted death.

#### 1. Attempts at Legalization

A number of state legislatures have considered bills that would legalize physician-assisted death,<sup>27</sup> but no state legislature has yet

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23. See *id.* at 2661. A total of 52% of all respondents indicated that they would consider alternatives to end their lives, including withholding of life support, physician-assisted suicide or euthanasia, and asking family or friends to help. See *id.* at 2660-61.

24. See *id.* at 2661.

25. *Id.* For a more detailed discussion of the societal desire to have physicians involved, see *infra* Part IV.

26. See *id.* at 2662.

27. See David R. Schanker, Note, *Of Suicide Machines, Euthanasia Legislation, and the Health Care Crisis*, 68 IND. L.J. 977, 1002-03 (1993) (describing bills introduced in the Iowa, Maine, Michigan, and New Hampshire legislatures in 1992 alone). More recently, state Senator Joseph Galiber introduced legislation in the New York State Senate that would legalize physician-assisted suicide for mentally competent, terminally ill adults. See *Legislation Introduced to Permit Physician-Assisted Suicide*, 3 Health L. Rep. (BNA) No. 25, at 851 (June 23, 1994).

passed such a measure.<sup>28</sup> In an attempt to sidestep these legislative bottlenecks, proponents have turned to the initiative processes within various states that allow them to present the question of legalization directly to the citizenry.<sup>29</sup> In 1991, the voters in Washington State were asked to pass upon Initiative 119, which would have legalized physician-assisted death.<sup>30</sup> Specifically, Initiative 119 contained a provision that would have allowed mentally competent adults with medically certified terminal conditions to legally request and receive "aid-in-dying" from their physicians as a "medical service."<sup>31</sup> Following heated and controversial campaigns on both sides of the issue, the voters rejected the initiative by a margin of fifty-four percent to forty-six percent.<sup>32</sup> One year later, the citizens of California rejected a similar proposal, entitled Proposition 161,<sup>33</sup> by an identical margin.<sup>34</sup>

The defeats of Initiative 119 and Proposition 161 were the result of remarkably successful campaigns by opponents to convince voters that the proposals lacked sufficient safeguards against abuse. In Washington, anti-Initiative 119 spokespersons regaled the public with long lists of safeguards that they claimed should have been included in

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28. In fact, a recent vote in the New Hampshire House, in which a bill to legalize physician-assisted suicide was overwhelmingly defeated, marked the first time a state legislature has even voted on such a measure. *See State Legislators Defeat Measure to Permit Physician-Assisted Suicide*, 5 Health L. Rep. (BNA) No. 2, at 57 (Jan. 11, 1996).

29. In 1988, the first such attempt failed when supporters of legalized physician-assisted death in California gathered less than one-third of the signatures necessary to place the issue on the ballot. *See* Victor Cohn, *Is It Time for Mercy Killing*, WASH. POST, Aug. 15, 1989, at Z12.

30. *See* Initiative for Death with Dignity, Washington Initiative No. 119 (1991) [hereinafter Initiative 119].

31. *See* Initiative 119 § 2(7). The initiative defined aid-in-dying as:

[A]id in the form of a medical service, provided in person by a physician that will end the life of a conscious and mentally competent qualified patient in a dignified, painless, and humane manner, when requested voluntarily by the patient through a written directive in accordance with this chapter at the time the medical service is to be provided.

Initiative 119 § 2(9).

32. *See Results*, SEATTLE TIMES, Nov. 6, 1991, at D6.

33. *See* The California Death with Dignity Act (Californians Against Human Suffering 1992) [hereinafter Proposition 161]. Proposition 161 defined aid-in-dying as:

[A] medical procedure that will terminate the life of the qualified patient in a painless, humane and dignified manner whether administered by the physician at the patient's choice or direction or whether the physician provides means to the patient for self-administration.

Proposition 161 § 2525.2(k).

34. *See* Lori Olszewski, *Right-to-Die Law Apparently a Loser*, S.F. CHRON., Nov. 4, 1992, at A12.

Initiative 119, but were not.<sup>35</sup> These lists included: a waiting period between the request and the provision of physician aid-in-dying, mandatory psychological testing of the individual to determine competency and rule out treatable depression, mandatory notification of family members, and a reporting requirement triggered whenever physicians administered aid-in-dying.<sup>36</sup> In California, even though Proposition 161 contained safeguards beyond those contained in the Washington proposal,<sup>37</sup> opponents once again successfully raised the specter of abuse.<sup>38</sup> The defeats in California and Washington did not,

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35. See Robin Bernhoft, *Initiative 119—Should Aid-In-Dying Be Allowed—No*, SEATTLE TIMES, Oct. 27, 1991, at A21; Susan Gilmore, *Death Initiative Divisive—No Middle Ground on Euthanasia Issue*, SEATTLE TIMES, Oct. 3, 1991, at B5; Warren King, *Hospitals Brace for Aid-in-Dying Requests*, SEATTLE TIMES, Oct. 11, 1991, at C1; Warren King, *Doctor, Patient Could Pick Means of Death—Initiative 119 Would Create First Such Law Anywhere in World*, SEATTLE TIMES, Oct. 24, 1991, at A1 (quoting Dr. Arthur Caplan); Warren King, *Doctors Group Declares War on 'Death with Dignity' Initiative*, SEATTLE TIMES, Oct. 24, 1991, at B6.

36. See *id.* Opponents also contended that Initiative 119 should have limited aid-in-dying to those individuals who were experiencing unbearable pain, and that only those physicians with experience and expertise in treating dying patients and an established doctor-patient relationship with the person requesting aid should be allowed to assist. See Edward Larson, *Washington State: The Nevada of Death?*, SEATTLE TIMES, Oct. 31, 1991, at A11.

37. Proposition 161 stated that a qualified individual must, in addition to executing an aid-in-dying directive, request assistance at least one more time in order to meet the "enduring request" requirement. See Proposition 161 § 2525.2(i). Proposition 161 also dealt explicitly with the potential need for psychiatric or psychological consultation by stating that "[a]n attending physician who is requested to give aid-in-dying may request a psychiatric or psychological consultation if that physician has any concern about the patient's competence, with the consent of a qualified patient." Proposition 161 § 2525.13. As a further safeguard, the California proposal provided that a directive executed by a patient in a skilled nursing facility would be invalid unless one of the two witnesses to the directive was a Patient Advocate or Ombudsman. See Proposition 161 § 2525.4. The intent of this section was to provide special protection for patients in nursing homes who might be "insulated from a voluntary decision-making role, by virtue of the custodial nature of their care." *Id.* Finally, Proposition 161 required hospitals and other health care providers who carried out the aid-in-dying directives to keep a record of those cases and report annually to the State Department of Health Services. See Proposition 161 § 2525.21. The patient's age, type of illness, and date of death were to be reported, but the patient's identity was to be kept strictly confidential. See *id.*

38. Opponents argued that the California proposition should have required a mandatory psychological evaluation, a waiting period between the aid-in-dying request and the actual assistance, and mandatory family notification. See Lori Olszewski, *Right-to-Die Advocate in S.F., He's Promoting Ballot Initiative Allowing Physician-Assisted Suicide*, S.F. CHRON., Aug. 28, 1992, at A25; Robert Reinhold, *California to Decide if Doctors Can Aid in Suicide*, N.Y. TIMES, Oct. 9, 1992, at A1. In addition, they contended that Proposition 161 was remiss in not including a requirement that the terminally ill individual be experiencing pain and that the assisting physician have special expertise in diagnosis and treatment of the dying. See Leslie Berkman, *O.C. in Middle of 'Death with Dignity' Debate*, L.A. TIMES, Oct. 4, 1992, at A1.

however, mark the end of the efforts by aid-in-dying proponents to place the issue before the citizenry.<sup>39</sup> Oregon was next, and as it turns out, the third time was the charm.

## 2. The Oregon Death with Dignity Act

On November 8, 1994, the citizens of Oregon approved Ballot Measure 16,<sup>40</sup> also called the Oregon Death with Dignity Act.<sup>41</sup> It allows a capable,<sup>42</sup> adult resident of Oregon<sup>43</sup> diagnosed with a terminal disease<sup>44</sup> to "make a written request for medication for the purpose of ending his or her life in a humane and dignified manner."<sup>45</sup> Physicians who write such prescriptions in good-faith compliance with the Act are immune from civil or criminal liability or professional discipline.<sup>46</sup> Oregon thus became the first jurisdiction in the world to explicitly legalize physician-assisted suicide.<sup>47</sup>

The authors of The Oregon Death with Dignity Act clearly crafted the statute to take into account the "inadequate safeguards"

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39. During 1992 alone, as many as 20 states had initiatives in the pipeline on the subject of physician-assisted death. See Blendon et al., *supra* note 19, at 2658.

40. See Mark O'Keefe, *Assisted-Suicide Measure Survives Heavy Opposition*, OREGONIAN, Nov. 10, 1994, at A1. The final tally was 51% in favor and 49% opposed. See Bill MacKenzie, *Whose Life Is It? Oregon Battles over Suicide Law*, NEWSDAY, Dec. 5, 1994, at A17.

41. See The Oregon Death with Dignity Act, OR. REV. STAT. §§ 127.800-895 (1995) [hereinafter Oregon Act].

42. An individual is "capable" if he or she has the ability to make and communicate health care decisions to the health care provider. See Oregon Act § 1.01(6).

43. The initiative contains an explicit residency requirement. See *id.* § 3.10. Presumably this section was included to prevent individuals from other states from flocking to Oregon to take advantage of the Act.

44. "Terminal disease" is defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." *Id.* § 1.01(12).

45. *Id.* § 2.01. The measure legalizes only physician-assisted suicide, stating that "[n]othing in this Act shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing or active euthanasia." *Id.* § 3.14. Thus, terminally ill individuals who are physically incapable of ingesting a lethal dose of prescription medication are prevented from receiving more direct physician assistance, such as a lethal injection, to end their lives.

46. See *id.* § 4.01(1). Without this provision, physicians who assisted a suicide would presumably be subject to prosecution under OR. REV. STAT. § 163.125 (1995), which makes it a crime to intentionally cause or aid another in committing suicide.

47. While physician-assisted suicide and euthanasia have been practiced in the Netherlands for years, such activities remain technically illegal. See *supra* note 13. In May 1995, the Northern Territory in Australia became the second jurisdiction to legalize physician-assisted death. See Bates, *supra* note 4, at A5. The Rights of the Terminally Ill Bill legalizes both physician-assisted suicide and lethal injection for qualified terminally ill Australians. See *id.*

complaints that had surfaced previously in Washington and California.<sup>48</sup> The most striking aspect of the Oregon measure is its high degree of procedural specificity. The terminally ill individual must first make an oral request of the attending physician, then a written request,<sup>49</sup> and finally another oral request before the physician may assist.<sup>50</sup> Once the initial oral request is made, the attending physician is required to inform the patient of the diagnosis, prognosis, risks, and results of taking the medication, as well as alternatives including comfort care, hospice care, and pain control.<sup>51</sup> The initiative requires a waiting period of fifteen days between the initial oral request and the writing of the prescription, and a minimum of forty-eight hours between the individual's written request and the writing of the prescription.<sup>52</sup> During the waiting period, the attending physician must refer the individual to a consulting physician for medical confirmation that the patient is terminally ill, mentally capable, and acting voluntarily;<sup>53</sup> send the individual for counseling if appropriate;<sup>54</sup> and request that the patient notify next of kin of the request for assistance.<sup>55</sup> Physicians are required to document every aspect of the process, particularly that the individual is acting voluntarily and that the decision is an informed one.<sup>56</sup>

As one might expect, Oregon's Ballot Measure 16 evoked a vigorous public response, both positive and negative.<sup>57</sup> The most

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48. In fact, one of the sections of the legislation is entitled "Safeguards." See Oregon Act § 3. However, the Act lacks a number of the safeguards proposed in the Washington and California debates such as mandatory counseling, mandatory family notification, an established physician-patient relationship, and a requirement that the terminally ill individual be suffering unbearable pain.

49. The initiative contains a form for the written request, *see id.* § 6.01, and requires that two witnesses attest to their belief that the patient is capable and acting voluntarily in signing the request. *See id.* § 2.02(1).

50. *See id.* § 3.06. At the time of the second oral request for a prescription, the physician must offer the individual an opportunity to rescind the request. *See id.*

51. *See id.* § 3.01(2)(a)-(e).

52. *See id.* § 3.08.

53. *See id.* § 3.01(3).

54. *See id.* § 3.01(4). If either the attending or consulting physician believes that the individual is suffering from depression causing impaired judgment or a psychiatric or psychological disorder, the attending physician must refer the patient for counseling. *See id.* § 3.03. No prescription may be written until the counselor determines that the individual is not suffering from any of these disorders. *See id.*

55. *See id.* § 3.01(5). An individual who declines or is unable to notify next of kin would still be entitled to receive assistance. *See id.* § 3.05.

56. *See id.* § 3.09.

57. *See, e.g.,* George J. Annas, *Death By Prescription: The Oregon Initiative*, 331 NEW ENG. J. MED. 1240, 1243 (1994) (taking the position that Oregon's Ballot Measure 16



significant response, however, came in the form of a lawsuit brought in federal district court by a group of physicians, residential care facilities, and terminally ill individuals who challenged the constitutionality of Ballot Measure 16.<sup>58</sup> While the plaintiffs attacked the statute on a number of grounds,<sup>59</sup> the Fourteenth Amendment challenge lies at the heart of their lawsuit. Specifically the plaintiffs asserted that Measure 16 violates due process and equal protection rights by failing to protect vulnerable terminally ill individuals who, due to severe undiagnosed depression or undue influence, will resort to physician assistance to end their lives prematurely.<sup>60</sup> These assertions should sound familiar: the plaintiffs merely recast the political cry of "insufficient safeguards" in constitutional terms. When faced with the initial question whether to enjoin the statute pending a determination on the merits, Judge Michael Hogan granted the plaintiffs' request for a preliminary injunction, stating, "[s]urely, the first assisted suicide law in this country deserves a considered, thoughtful constitutional analysis."<sup>61</sup> Eight months later, Judge Hogan struck down Oregon's Death with Dignity Act on equal protection grounds<sup>62</sup> in a decision that, unfortunately, falls short of his stated goal.

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will do more harm than good for the terminally ill); *The Oregon Death with Dignity Act [Letters]*, 332 NEW ENG. J. MED. 1174, 1174-75 (1995) (responses to Professor Annas); Robert A. Burt, *Death Made Too Easy*, N.Y. TIMES, Nov. 16, 1994, at A19 (asserting that physician-assisted suicide should not be the first or only response to the social isolation and abandonment currently experienced by the dying); Timothy Egan, *Suicide Law Placing Oregon on Several Uncharted Paths*, N.Y. TIMES, Nov. 25, 1994, at A1 (quoting both opponents and proponents of the measure); Diane M. Gianelli, *Oregon Doctors Fear Fallout from Assisted Suicide*, AM. MED. NEWS, Jan. 23/30, 1995, at 1 (describing physicians' reactions to the law); Leon R. Kass, *Death by Ballot in Oregon*, WALL ST. J., Nov. 2, 1994, at A14 (arguing that Oregon's Ballot Measure 16 is both unnecessary and dangerous); *Doctor-Assisted Suicide Gives Patient 'Freedom' [Letters]*, WALL ST. J., Nov. 14, 1994, at A11 (responses to Dr. Kass).

58. See *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994). The constitutional challenge was filed in federal district court in Oregon two weeks before the Act was scheduled to take effect. See *Suit Challenges Assisted-Suicide Law in Oregon*, L.A. TIMES, Nov. 25, 1994, at A26.

59. The plaintiffs alleged that Ballot Measure 16 violates the 14th Amendment's Due Process and Equal Protection Clauses, the First Amendment's Freedom of Religion and Association Clauses, and the Americans with Disabilities Act. See *Lee*, 869 F. Supp. at 1493.

60. See *id.* at 1496-97.

61. *Id.* at 1502-03; see also *Ruling Blocks Suicide Law*, N.Y. TIMES, Dec. 28, 1994, at 10.

62. See *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995). Because Judge Hogan found the statute unconstitutional on equal protection grounds, he did not find it necessary to rule on the plaintiffs' additional constitutional and statutory claims. See *id.* at 1437.

Ballot Measure 16 operates on the implicit premise that physician-assisted suicide, when freely chosen by a capable, informed, terminally ill adult, is rational. It is the rationality of the choice to end one's own life under these circumstances that arguably justifies the State's willingness to treat these individuals differently from other "irrational" persons who desire assistance in ending their lives.<sup>63</sup> It should come as no surprise, then, that a large portion of Ballot Measure 16 is devoted to setting up a statutory scheme by which physicians can distinguish between individuals who fall within the statutory class (terminally ill persons who voluntarily and rationally choose assisted suicide) and those who fall without.<sup>64</sup>

Judge Hogan's ruling centers on the adequacy of Oregon's procedures for determining which individuals qualify for physician-assisted suicide. He held that the Act lacked sufficient safeguards to protect terminally ill individuals whose consent to assisted suicide might be colored by undiagnosed depression or outside coercion, and that this lack of safeguards rose to the level of an equal protection violation.<sup>65</sup> According to the court, the specific failings of the statutory scheme included: (1) allowing physicians who may not be mental-health specialists to assess whether the patient is suffering from a psychiatric or psychological disorder or depression causing impaired judgment,<sup>66</sup> (2) allowing physicians to determine whether the person's request is voluntary rather than being a product of undue influence,<sup>67</sup> (3) failing to provide for an independently chosen consulting physician to confirm that the person is capable and the choice voluntary,<sup>68</sup> (4) holding physicians to a good-faith standard of care under the Act rather than an objectively reasonable one,<sup>69</sup> and (5) failing to require assessment of the individual's psychological state and circumstances at the time of the suicide.<sup>70</sup> According to Judge Hogan, these procedural infirmities combined to produce a "severely overinclusive class who

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63. This difference in treatment takes the form of a statutory immunity from criminal or civil liability or professional discipline for those persons who, in good faith, assist a terminally ill individual to commit suicide under the Act. *See Oregon Act § 4.01(1)*.

64. *See Oregon Act §§ 1-3; see also supra* notes 49-56 and accompanying text.

65. *See Lee*, 891 F. Supp. at 1437.

66. *See id.* at 1435.

67. *See id.*

68. *See id.* at 1435-36.

69. *See id.* at 1436-37.

70. *See id.* at 1437.

may be competent, incompetent, unduly influenced, or abused by others."<sup>71</sup>

Judge Hogan is clearly right in concluding that a statute legalizing physician-assisted suicide could be so lacking in safeguards as to violate the Equal Protection Clause of the Constitution. He is also undoubtedly correct in asserting that Oregon's Death with Dignity Act could have been drafted in such a way as to provide more procedural protections to terminally ill individuals. The astonishing aspect of his decision is that he struck down this particular statute, which clearly contains a number of safeguards, while purporting to use a rational basis standard of review.<sup>72</sup> In the course of his analysis, Judge Hogan acknowledges that under that standard, he must uphold the statutory classification against equal protection challenge "if there is any reasonably conceivable state of facts that could provide a rational basis for the classification."<sup>73</sup> But he then proceeds to use this supposedly deferential standard to strike provision after provision of the Act.

Consider, for example, the court's discussion of the statutory procedures that would allow physicians other than psychiatrists or mental-health specialists to assess whether an individual suffers from depression or another psychiatric condition that would affect his or her decision-making capacity.<sup>74</sup> Judge Hogan first attacks the Act's failure to provide for decisionmaking through the use of "substituted judgment," which he asserts is a safeguard present in withdrawal-of-life-support cases but conspicuously absent from Measure 16.<sup>75</sup> The notion that the Oregon Death with Dignity Act would be more protective had it incorporated the use of substituted judgment is simply wrong. Substituted judgment allows a third party to make a medical treatment decision on behalf of an *incompetent* person.<sup>76</sup> In limiting

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71. *Id.*

72. Plaintiffs argued that the statutory classification is not rationally related to a legitimate state interest. *See id.* at 1431 & n.2.

73. *Id.* at 1432 (quoting *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 311-12 (1993)).

74. Judge Hogan tends to use the terms "capacity" and "competency" interchangeably in his opinion. Technically, the term "capacity" refers to an individual's ability to make decisions as a factual matter, whereas "competency" refers to an individual's legal status to make decisions. *See* 1 ALAN MEISEL, *THE RIGHT TO DIE* 173 (1989). The Oregon Death with Dignity Act defines a qualified patient as one who is "capable." *See* Oregon Act § 1.01(11).

75. *See Lee*, 891 F. Supp. at 1434.

76. *See id.* The substituted-judgment standard as used in treatment-withdrawal cases calls upon a surrogate decisionmaker to make medical decisions in accordance with what the

physician-assisted suicide to capable individuals,<sup>77</sup> Ballot Measure 16 specifically avoids the pitfalls and potential abuses inherent in such third-party decisionmaking. Thus, the Act is *more* protective of terminally ill individuals than if it contained the "safeguard" that the court proposes.

Judge Hogan next points to Oregon's involuntary civil commitment statute, and the provision therein requiring evaluation by a psychiatrist prior to a commitment hearing.<sup>78</sup> He concludes from this comparison that Ballot Measure 16 is unconstitutional because it fails to include a similar requirement.<sup>79</sup> His analogy to involuntary civil commitment proceedings is inapposite for several reasons. First, civil commitment proceedings are by definition involuntary. They are initiated only when an individual has exhibited symptoms or signs of a mental illness and a propensity to endanger himself or others. In this context, evaluation by a licensed psychiatrist operates to protect the person from state overreaching in the form of an erroneous involuntary commitment. In marked contrast, physician-assisted suicide is, by Oregon's statutory definition, voluntary. Further, assuming the statutory premise of rational suicide, a terminally ill individual who requests assisted suicide does not exhibit irrationality or symptoms of mental illness merely by making the request; he or she is entitled to the same presumption of competence or capacity that is accorded everyone else. Finally, mandatory psychiatric evaluation in the physician-assisted suicide context would operate to protect an individual not so much from the state but from herself and her own choices.

Even if one concedes that mandatory psychiatric evaluation would operate as an additional safeguard for the terminally ill who are contemplating assisted suicide,<sup>80</sup> it does not follow that failure to include such a requirement is unconstitutional under a rational review standard. Physicians who are not psychiatrists make implicit judgments every day as to their patients' medical decision-making capacities. Furthermore, they do so in contexts such as the withdrawal

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incompetent individual would have wished had she been competent. See 1 MEISEL, *supra* note 74, at 270-72.

77. See Oregon Act § 1.01(11) (defining a qualified patient as one who is capable).

78. See *Lee*, 891 F. Supp. at 1434-35.

79. See *id.* at 1435-36.

80. The argument here is that psychiatrists are better trained to diagnose depression and other psychiatric disorders that may impair judgment or lead to lack of decision-making capacity. See *id.*

of life support, where, similar to physician-assisted suicide, the end result of the person's decision may be his or her death. In addition to making judgments concerning an individual's decision-making capacity, non-psychiatrist physicians (including family practice physicians and internists) both diagnose and treat depression as a regular part of their medical practices. Given this state of affairs, it is difficult to understand how statutory procedures that allow physicians other than psychiatrists to make those same judgments in the physician-assisted-suicide setting are irrational or unrelated to legitimate state objectives. While strong public policy reasons may exist for requiring psychiatric consultation prior to physician-assisted suicide, the question here is one of constitutionality and not merely the wisdom of Oregon's statutory scheme.<sup>81</sup>

A similar critique can be applied to the standard-of-care analysis. The court states that Oregon's use of a good faith rather than a negligence standard of care "is not rationally related to any legitimate state interest."<sup>82</sup> But surely it is not irrational for the legislature (or the citizenry in this case) to conclude that, without immunity from civil liability for negligence, many health care providers would be reluctant to enter such a controversial and uncertain area of medical practice. Nor would it be irrational to conclude that the statutory purpose of providing terminally ill individuals with the choice of physician-assisted suicide would be best effectuated by providing such immunity.

It appears that something other than a rational-basis review took place in the Oregon court. Judge Hogan simply did not accept the premise that a person can provide truly voluntary and rational consent to assisted death.<sup>83</sup> Instead, he seemed to assume that terminally ill individuals who would choose death are presumptively incompetent until declared otherwise by an expert.<sup>84</sup> Such a belief, that persons

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81. The court also expresses concern over the lack of a referral requirement to a "certified social worker" or other specialist to explore social services available to the terminally ill individual. *See id.* Again, it is difficult to take seriously the position that such a requirement is constitutionally mandated.

82. *Id.* at 1437.

83. Judge Hogan's skepticism comes through most clearly in footnotes, where he raises the specter of the slippery slope, *see id.* at 1432-33 n.3, questions whether the Constitution can distinguish between classes of people for whom assisted suicide would be rational, *see id.*, and asserts that it would be equally rational to conclude that no person could benefit from self-destruction. *See id.* at 1434 n.6.

84. How else to explain his statement that "[u]nder Measure 16, the very lives of terminally ill persons depend on their own rational assessment of the value of their existence, and yet there is no requirement that they be evaluated by a mental health specialist"? *Id.* at 1438.

who would choose assisted suicide are irrational and need to be protected from themselves, drives a constitutional analysis that is simply unsupportable.<sup>85</sup> Not surprisingly, the State of Oregon appealed the district court's decision. Should the Ninth Circuit reverse and uphold the constitutionality of Ballot Measure 16,<sup>86</sup> legalized physician-assisted suicide will be a reality in Oregon.

### C. Criminalizing Physician-Assisted Death

Based on the initiative processes in Washington, California, and Oregon, one might be inclined to assume that the political trend has been solely in the direction of legalizing physician-assisted death. In fact, several states have moved in exactly the opposite direction, creating criminal prohibitions on assisted suicide where none have existed before. The states of Tennessee and Kentucky, for example, enacted statutes making assisted suicide a felony,<sup>87</sup> and in so doing, joined the majority of states that have long criminalized assisted suicide.<sup>88</sup>

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85. I do not criticize Judge Hogan for holding these views. Rather, I am concerned with his questionable use of constitutional doctrine to strike down a statute that he thinks is unwise.

86. In an unusual move, the Ninth Circuit has signaled that it will likely reverse the district court decision in *Lee*. In ruling in a different case involving a challenge to Washington's ban on assisted suicide, see *infra* Part IIC2, the en banc panel expressed its disapproval of both Judge Hogan's reasoning and conclusions. See *Compassion in Dying v. Washington*, 79 F.3d 790, 837-38 (9th Cir. 1996) (en banc), *cert. granted sub nom. Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110). The court explained that Judge Hogan had "clearly erred" in treating a benefit (the right to physician-assisted suicide) as a burden and a burden (the statute prohibiting assisted suicide) as a benefit. *Id.* at 838.

In light of the court's language and holding in *Compassion in Dying*, the State of Oregon filed a motion with the Ninth Circuit asking that it lift the injunction currently operating against the Oregon law. See 5 Health L. Rep. (BNA) No. 11, at 395 (Mar. 14, 1996). The Ninth Circuit denied the motion, stating that Oregon should ask the district court to lift the injunction. See 5 Health L. Rep. (BNA) No. 12, at 433 (Mar. 21, 1996). Judge Hogan has since denied Oregon's motion; the appeal of the original decision in *Lee* remains before the Ninth Circuit.

87. See *Legislature Repeals Provider Tax, Makes Aiding Suicides a Felony Offense*, 2 Health L. Rep. (BNA) No. 21, at 683 (May 27, 1993) (Tenn.); *New Law Makes Suicide Assistance Punishable by Up to 10-Year Prison Term*, 3 Health L. Rep. (BNA) No. 15, at 494 (Apr. 14, 1994) (Ky.).

88. The following states currently prohibit and provide criminal sanctions for assisting in suicide: ALASKA STAT. § 11.41.120(a)(2) (Michie 1985); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (West Supp. 1996); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1993); CAL. PENAL CODE § 401 (Deering 1985); COLO. REV. STAT. ANN. § 18-3-104(1)(b) (West 1986); CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 1996); DEL. CODE ANN. tit. 11, § 645 (1995); FLA. STAT. ANN. § 782.08 (West 1992); HAW. REV. STAT. § 707-702(b) (1995); 720 ILL. COMP. STAT. ANN. 5/12-31(a)(2) (West Supp. 1996); IND. CODE ANN. § 35-42-1-2.5

In an interesting contrast to the Oregon litigation, these statutes have recently come under constitutional attack. Here the question is not whether a state can constitutionally legalize assisted suicide, but rather, whether a state can constitutionally prohibit it. Proponents of physician-assisted death have a strong incentive to concentrate their efforts in this area. If they can prevail in their view that laws prohibiting assisted suicide violate the Federal Constitution, the question in every state immediately shifts from *whether* to legalize assisted suicide, to *how* to regulate it. Thus far, constitutional challenges have been raised in three states: Michigan, Washington, and New York. The challenge began in Michigan, with Jack Kevorkian leading the way.

### 1. Michigan

When Kevorkian first began his crusade in 1990 by hooking Janet Adkins up to his "suicide machine,"<sup>89</sup> Michigan did not have a statute on the books making assisted suicide a crime. The Michigan

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(Michie Supp. 1996); KAN. STAT. ANN. § 21-3406 (1995); KY. REV. STAT. ANN. § 216.300.308 (Michie 1995); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1995); 1992 Mich. Pub. Acts 270 (temporary statute, no longer in effect); MINN. STAT. ANN. § 609.215 (West Supp. 1996); MISS. CODE ANN. § 97-3-49 (1995); MO. ANN. STAT. § 565.023.1(2) (West 1995); MONT. CODE ANN. § 45-5-105 (1995); NEB. REV. STAT. § 28-307 (1995); N.H. REV. STAT. ANN. § 630:4 (1995); N.J. STAT. ANN. § 2C:11-6 (West 1995); N.M. STAT. ANN. § 30-2-4 (Michie 1995); N.Y. PENAL LAW § 120.30 (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (Supp. 1996); OKLA. STAT. ANN. tit. 21, §§ 813-818 (West 1983); OR. REV. STAT. § 163.125(1)(b) (1995); 18 PA. CONS. STAT. ANN. § 2505(b) (West 1983); S.D. CODIFIED LAWS §§ 22-16-37 & -38 (Michie 1988); TENN. CODE ANN. § 39-13-216 (Supp. 1996); TEXAS PENAL CODE ANN. § 22.08 (West 1994); WASH. REV. CODE ANN. § 9A.36.060 (West 1988); WIS. STAT. ANN. § 940.12 (West 1996).

89. Janet Adkins was a 54-year-old woman who had been diagnosed with Alzheimer's disease. See Lawrence K. Altman, *The Doctor's World: Use of Suicide Device Sets in Motion Debate on a Disturbing Issue*, N.Y. TIMES, June 12, 1990, at C3. She was evidently in the early stages of the disease, suffering from forgetfulness but still able to function. See Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES, June 6, 1990, at A1. In 1990, after learning of Dr. Kevorkian through local newspapers, Ms. Adkins flew from her home in Oregon to seek Dr. Kevorkian's aid in ending her life. See *id.* Dr. Kevorkian met with Janet Adkins and her husband and ultimately agreed to assist. See *id.* After unsuccessfully trying to locate a place that would allow him to carry out the procedure, Kevorkian resorted to using his Volkswagen van, which he had equipped with a cot, curtains, and his suicide machine. See *id.* He inserted an intravenous tube in Ms. Adkins' arm that dripped saline solution. See *id.* When Ms. Adkins was ready, she pressed a button that released thiopental into her vein, causing her to lose consciousness. See *id.* The machine then released potassium chloride, which stopped Ms. Adkins' heart and caused her death within a few minutes. See *id.*

Legislature, propelled by Kevorkian's continued activities,<sup>90</sup> passed a statute which set up a commission to study the issue and temporarily criminalized assisted suicide.<sup>91</sup>

The threat of prosecution under the new law did not stop Kevorkian—if anything, it spurred him on.<sup>92</sup> But there was method in his madness; in deliberately flouting the law, he was able to directly challenge its constitutionality. Three times he was charged,<sup>93</sup> and in two of those cases the statute was declared unconstitutional.<sup>94</sup> But the

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90. See *supra* note 9. Prosecutors' early attempts to try Kevorkian on murder charges were unsuccessful. See Tamar Lewin, *Doctor Cleared of Murdering Woman with Suicide Machine*, N.Y. TIMES, Dec. 14, 1990, at B6 (stating that judge dismissed murder charges in Adkins case because Ms. Adkins and not Dr. Kevorkian caused her death); *Murder Charges Against Kevorkian are Dismissed*, N.Y. TIMES, July 22, 1992, at A12 (detailing ruling in which judge held that, at most, Kevorkian assisted in suicide and Michigan does not bar assisted suicides).

91. The original bill proposed to set up a commission, which was to be given 15 months to develop recommendations for the legislature concerning voluntary self-termination of life. See *Hobbins v. Attorney Gen.*, 518 N.W.2d 487, 490 (Mich. Ct. App.), *aff'd in part and rev'd in part sub nom. People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). But as the number of Kevorkian-assisted deaths mounted, the legislature amended the bill to add a provision that would temporarily criminalize assisted suicide. See *id.* at 490. The amended bill prohibited a person who has knowledge that another intends to commit suicide from intentionally providing the physical means or participating in a physical act by which another attempts or commits suicide. See MICH. COMP. LAWS ANN. § 752.1027 (West 1993). Criminal assistance to suicide was made a felony punishable by not more than four years in prison. See *id.* The bill provided, however, that the criminal proscriptions would be automatically repealed six months after the commission made its recommendations to the legislature. See *id.* § 752.1027(5). The Michigan Legislature passed the amended version in December 1992 and then moved its effective date from March 30, 1993 to February 25, 1993, after Kevorkian assisted in nine deaths between December and February alone. See *Kevorkian-Aided Suicide Investigated as Homicide*, N.Y. TIMES, Feb. 26, 1993, at A10; *Kevorkian Aids in 2 More Suicides; Total Is at 15*, N.Y. TIMES, Feb. 19, 1993, at A10.

92. See *Kevorkian, Pushing for Jail, Aids in Suicide in His Home*, N.Y. TIMES, Oct. 23, 1993, at 8 (stating that Kevorkian had assisted a suicide in his own home in an attempt to provoke authorities into jailing him).

93. See Don Terry, *As He Hoped, Kevorkian Is Charged in a Suicide*, N.Y. TIMES, Aug. 18, 1993, at A12; *Kevorkian Charged a 2d Time Under Suicide Law*, N.Y. TIMES, Sept. 15, 1993, at A20; *Kevorkian Is Charged Again with Aiding a Suicide*, N.Y. TIMES, Nov. 30, 1993, at A18.

94. See *Suicide Law Struck Down, but Kevorkian Stays Jailed*, N.Y. TIMES, Dec. 14, 1993, at A18 (noting that the court found that the statute infringes impermissibly on liberty interests guaranteed by the U.S. Constitution); *Aided-Suicide Law Invalidated Again*, N.Y. TIMES, Jan. 28, 1994, at A17 (noting that the court found that the statute violates state constitution because legislature amended bill to change its original purpose and bill has more than one objective). The Michigan statute had previously been declared unconstitutional in a declaratory judgment action brought by a group of terminally ill individuals and health-care providers. See Isabel Wilkerson, *Suicide Law Struck Down, for Now*, N.Y. TIMES, May 21, 1993, at B9. The judge in that action held that the law violated the state constitution because it had been passed by the legislature without a public hearing



criminal charges stuck in a third case, in which Kevorkian went out of his way to force a trial because he was convinced that a jury would not

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and because it contained more than one objective. *See id.* The court also found a due-process right to commit suicide but denied the plaintiffs' motion for a preliminary injunction, holding that hearings would be necessary to determine whether the statute unduly burdened the right. *See People v. Kevorkian*, 527 N.W.2d 714, 717 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).

At the same time that the State proceeded with its prosecution of Kevorkian in the "Hyde case," *see infra* note 95 and accompanying text, it appealed the three lower-court decisions holding the assisted-suicide statute to be unconstitutional. On consolidated appeal, the Michigan appellate court affirmed all three decisions by a 2-1 vote, but it did so on the narrow state constitutional ground that the legislation violated the "one object" provision of the Michigan Constitution because it contained two objects: criminalizing assisted suicide and setting up a study commission. *See Hobbins v. Attorney Gen.*, 518 N.W.2d at 489-92. A different two-judge majority also opined that the statute did not violate the Federal Constitution because the Constitution does not guarantee a right to assisted suicide. *See id.* at 492-94.

Simultaneous with the above ruling, the appellate court issued an opinion in a companion case also involving Jack Kevorkian, in which he had been charged with murder for assisting two women to commit suicide prior to the effective date of Michigan's new assisted-suicide statute. *See Doctor Faces Murder Trial for Suicide Aid*, N.Y. TIMES, Feb. 29, 1992, at 10. The trial court judge had dismissed the murder charges, ruling that since the two women tripped the suicide devices themselves, Kevorkian could not be charged with homicide. *See Murder Charges Against Kevorkian Are Dismissed*, N.Y. TIMES, July 22, 1992, at A12. The Michigan Court of Appeals reversed and reinstated the murder charges, holding that Michigan's common-law definition of murder encompassed the act of aiding a suicide. *See People v. Kevorkian*, 517 N.W.2d 293, 295-98 (Mich. Ct. App.), *vacated*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).

The Supreme Court of Michigan granted leave to appeal in both the assisted-suicide and murder cases. *See People v. Kevorkian*, 521 N.W.2d 4, *aff'd in part and rev'd in part*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). In a rather splintered opinion, the Michigan Supreme Court ultimately ruled in late 1994 that the assisted-suicide provisions were validly enacted and did not violate the "Title object" provision of the state constitution, *see People v. Kevorkian*, 527 N.W.2d at 716; that the Due Process Clause of the U.S. Constitution does not encompass a fundamental right to assisted suicide so that Michigan may constitutionally prohibit such conduct, *see id.* at 733; that a defendant who assists a suicide may be prosecuted for common-law murder only if probable cause exists that the "death was the direct and natural result of the defendant's act," *id.* at 738; and that even in the absence of a statute prohibiting assisted suicide, such actions could still be prosecuted as the common-law offense of assisted suicide under a statutory saving clause. *See id.* at 739. The United States Supreme Court denied Kevorkian's certiorari petition in April 1995. *See Hobbins v. Kelley*, 115 S. Ct. 1795 (1995); *see also* Linda Greenhouse, *Court Won't Hear Appeal in Case of Assisted Suicide*, N.Y. TIMES, Apr. 25, 1995, at A17.

Michigan's statutory ban on assisted suicide automatically expired on November 25, 1994 (six months after the commission issued its report). The Michigan Supreme Court decision to both uphold Michigan's temporary ban on assisted suicide and to recognize a common-law felony of assisting suicide has not stopped Kevorkian's activities, *see supra* note 9, but no additional charges have been brought against Kevorkian since November 1993. *See Body in Auto Is Reported to Be Kevorkian's 26th Assisted Suicide*, N.Y. TIMES, Nov. 9, 1995, at A17; *Woman Dies at Kevorkian Clinic*, N.Y. TIMES, June 27, 1995, at A12.

convict him for his actions.<sup>95</sup> After four long years, Kevorkian finally faced a jury of his peers.<sup>96</sup> Incredibly, the jury acquitted him,<sup>97</sup> even though he had done everything but proclaim in open court that he had violated the law against assisted suicide.<sup>98</sup> The jury's willingness to acquit him in a case where he had clearly violated the plain language and intent of the statute<sup>99</sup> sent a strong message about the public's reticence to convict "physicians" for acts of assisted suicide. This message was only reinforced by Kevorkian's acquittal in two subsequent prosecutions, in which he switched tactics, claiming that he never intended to cause the death of his patients but only to relieve their suffering.<sup>100</sup> As important as these distinctions are, Kevorkian's

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95. See *Kevorkian Details His Role in Suicide*, N.Y. TIMES, Aug. 7, 1993, at 28. Thomas W. Hyde Jr. was a thirty-year-old man who suffered from amyotrophic lateral sclerosis (Lou Gehrig's disease), which causes progressive loss of all motor function. See *Kevorkian Said to Face Charge*, N.Y. TIMES, Aug. 17, 1993, at A12. Kevorkian assisted Mr. Hyde in taking his own life through the use of carbon monoxide. See *id.*

96. See *Trial Is Ordered for Suicide Doctor*, N.Y. TIMES, Feb. 19, 1994, at 9 (containing a statement by the judge that he was not bound by prior rulings in other Michigan counties declaring the statute unconstitutional).

97. See David Margolick, *Jury Acquits Dr. Kevorkian of Illegally Aiding a Suicide*, N.Y. TIMES, May 3, 1994, at A1.

98. In statements to the media, Kevorkian claimed, "I supplied the van . . . I drove him to Belle Isle. I supplied the gas. I supplied the tubing and the mask and all the necessary equipment. I connected the tubing [to the tank of carbon monoxide] . . . I put the mask on Mr. Hyde's face . . ." *Kevorkian Details His Role in Suicide*, N.Y. TIMES, Aug. 7, 1993 at 28.

99. The jury acquitted Kevorkian of providing the physical means or participating in an act of suicide, evidently by finding that Kevorkian's actions fell within an exception in the statute for persons administering medication or procedures "if the intent is to relieve pain or discomfort and not to cause death." See MICH. COMP. LAWS ANN. § 752.1027(3) (West Supp. 1994) (emphasis added).

As Yale Kamisar notes, the jury effectively negated the law when it used this exception to acquit Kevorkian. See Margolick, *supra* note 97, at A1. The Michigan Legislature included the language in question to prevent prosecutions in cases where medications administered for pain relief had the unintended effect of hastening or increasing the risk of death. The provision thus reassured physicians that they would not be prosecuted if medications they prescribed contributed to a patient's death, as long as the physician's intent in prescribing the drugs was to relieve pain rather than to cause death. See Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 NEW ENG. J. MED. 1039, 1039 (1993). Kevorkian's actions, based on his earlier statements and testimony at trial, simply do not fall within this exception, in that he clearly intended from the beginning to use the carbon monoxide to bring about Mr. Hyde's death. See *Kevorkian Takes Stand in Own Defense*, N.Y. TIMES, Apr. 28, 1994, at A16 (relating trial testimony in which Kevorkian stated that he used carbon monoxide to end Mr. Hyde's suffering and that he "had a fairly good idea that [Hyde] would die.").

100. The first of these most recent prosecutions arose from charges against Kevorkian for assisting in the 1993 carbon monoxide deaths of Merian Frederick and Dr. Ali Khalili in violation of Michigan's temporary assisted-suicide statute. See *Kevorkian and the Issue of Assisted Suicide Will Go on Trial for Second Time*, N.Y. TIMES, Feb. 12, 1996, at A10. The

legal maneuvers may have left an even more important legacy in the realm of constitutional law. The constitutional question of whether the Fourteenth Amendment prohibits states from banning physician-assisted death, first raised by Jack Kevorkian in Michigan, now occupies center stage in two cases arising out of direct challenges to such statutory bans in Washington and New York.<sup>101</sup>

## 2. Washington

In *Compassion in Dying v. Washington*,<sup>102</sup> a coalition of terminally ill patients, physicians who treat the terminally ill, and an

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charges were reinstated following the Michigan Supreme Court's decision upholding the constitutionality of that statute. See *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), cert. denied, 115 S. Ct. 1795 (1995); see also *supra* note 94. At trial, Kevorkian testified that his sole intent in assisting Frederick and Khalili was not to end their lives but rather to end their suffering. See *Kevorkian Says He Aims to Ease Suffering, Not to Hasten Death*, N.Y. TIMES, Mar. 6, 1996, at A19. The jury was ultimately convinced that Kevorkian's actions fell within the statutory exception for the administration of medication with the intent to relieve pain and not to cause death; they voted to acquit Kevorkian after deliberating for less than nine hours. See Jack Lessenberry, *Kevorkian Again Not Guilty of Aiding Suicide*, N.Y. TIMES, Mar. 9, 1996, at 7.

Shortly after the acquittal, Kevorkian stood trial for assisting in the deaths of Marjorie Wantz and Sherry Miller. These charges were also reinstated following the Michigan Supreme Court's decision, but were based on the common-law crime of assisting suicide rather than Michigan's temporary statute. See Jack Lessenberry, *After Victory, a New Trial for a Weary Kevorkian*, N.Y. TIMES, Mar. 11, 1996, at A13; see also *People v. Kevorkian*, 527 N.W.2d at 714 (declaring that the charge of assisting in a suicide is to be prosecuted as a common-law felony). This case was more difficult for both sides to try—the prosecution had to convince the jury that Kevorkian had violated a law that could not be found within the codified laws of Michigan and Kevorkian had to convince the jury that his actions were appropriate even though neither of the women he assisted was terminally ill. See *Kevorkian Faces Suicide Prosecution Without a Law Being Cited*, N.Y. TIMES, Apr. 17, 1996, at A20. Kevorkian again defended himself on the ground that his purpose as a physician was to relieve pain and suffering and that, in the cases of Wantz and Miller, that purpose could only be accomplished by treatment that caused their deaths. See Jack Lessenberry, *Specialist Testifies Depression Was Issue in Kevorkian Cases*, N.Y. TIMES, Apr. 24, 1996, at A17. The jury once again voted to acquit, in what many believe will be the last criminal prosecution brought against Kevorkian. See Jack Lessenberry, *Jury Acquits Kevorkian in Common-Law Case*, N.Y. TIMES, May 15, 1996, at A14. Defense counsel evidently carried the day with his argument that Kevorkian should not be found guilty for having committed the crime of assisted suicide in 1991 when the Supreme Court of Michigan did not even make it clear that such actions constituted a common law-crime until 1994. See *id.*; see also *supra* note 94 (describing the Michigan decisions).

101. I have chosen to focus on the Washington and New York cases rather than the Kevorkian cases in Michigan because the latter involved additional state constitutional and common-law claims that complicate the holdings and add little to the federal constitutional analysis. For a brief description of the Michigan decisions, see *supra* note 94.

102. 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), cert. granted *sub nom.* *Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110).

organization called "Compassion in Dying"<sup>103</sup> mounted a facial challenge to the constitutionality of the Washington statute that makes assisting a suicide a crime.<sup>104</sup> The plaintiffs challenged the statute only to the extent that it bars physician-assisted suicide by mentally competent, terminally ill adults who knowingly and voluntarily seek to end their lives by taking a lethal dose of prescription drugs.<sup>105</sup>

From the beginning, *Compassion in Dying* raised a fascinating question regarding the interpretation of Supreme Court precedent. On the one hand, the district court could look to the 1990 *Cruzan v. Director, Missouri Department of Health* decision,<sup>106</sup> the only case in which the Supreme Court has been called upon directly to decide whether there is a federal constitutional "right to die" embodied within the Due Process Clause of the Fourteenth Amendment.<sup>107</sup> In that case,

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103. Compassion in Dying is an organization devoted to providing support, counseling, and assistance to terminally ill adults contemplating suicide through self-administration of prescription drugs. *See id.* at 1458. The organization contends that terminally ill adults have the constitutional right to request assistance from its members, whose services include delivering or mixing the drugs to be used in the suicide. *See id.* at 1459. As of 1993, Compassion in Dying had assisted two individuals to commit suicide by helping them obtain lethal drugs and was counseling five to ten others. *See* Warren King, *Seattle Group Assists Second Person in Suicide*, SEATTLE TIMES, Aug. 31, 1993, at B1. The organization joined the lawsuit because its members feared criminal prosecution under the statute for their actions in assisting terminally ill individuals to commit suicide. *See Compassion in Dying*, 850 F. Supp. at 1459.

104. *See id.* at 1456. The statute in question makes it a crime to knowingly aid another person in committing suicide. *See* WASH. REV. CODE ANN § 9A.36.060 (West 1988) ("A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide."). Promoting a suicide is a Class C felony, *see id.* § 9A.36.060(2), which is punishable by imprisonment for a maximum of five years, or a fine of up to ten thousand dollars, or both. *See id.* § 9A.20.021(1)(c) (West 1988).

105. *See Compassion in Dying*, 850 F. Supp. at 1456. The plaintiffs sought a declaratory judgment striking down the statute, and injunctive relief barring its enforcement. *See id.*

106. 497 U.S. 261 (1990). Nancy Cruzan was an incompetent individual who had been in a persistent vegetative state for a number of years and who was being cared for in a Missouri state hospital at state expense. *See id.* at 265-66. The state of Missouri refused to honor her parents' requests to withdraw life-sustaining treatment, in this case artificial nutrition and hydration, in order to allow her to die. *See id.* at 267-68. Missouri premised its refusal on both the lack of clear and convincing evidence of Nancy Cruzan's wishes and the State's interest in the preservation of human life. *See id.* at 280-82.

107. *See id.* at 277. ("This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a 'right to die.'").

Leon Kass points out the confusion in public discourse over the meaning of the term "right to die." *See* Leon R. Kass, *Is There a Right to Die?*, 23 HASTINGS CENTER REP., Jan.-Feb. 1993, at 34, 36. According to Kass, it is variously used to refer to the "right to refuse treatment even if, or so that, death may occur; right to be killed or to become dead; right to control one's own dying; right to die with dignity; right to assistance in death." *Id.* Thus, in this context particularly, it is important to clarify the intended meaning of such terms.

the Supreme Court, in a 5-4 decision authored by Chief Justice Rehnquist, upheld the State's power to require that evidence of an incompetent's wishes for the withdrawal of life-sustaining treatment be proven by clear and convincing evidence.<sup>108</sup> Although *Cruzan* has repeatedly been cited in the media for the proposition that competent individuals have a constitutional right to die,<sup>109</sup> Rehnquist's opinion is notable for the ways in which it explicitly and implicitly limited this so-called constitutional right. First, he made it clear that, in his view, the holding was a narrow one confined entirely to the factual circumstances presented by the case.<sup>110</sup> Second, Rehnquist went out of his way to avoid holding that there is a constitutional right to refuse life-sustaining treatment. For purposes of this case only, he agreed to assume "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."<sup>111</sup> Third, he expressly rejected the characterization of this assumed interest as a privacy right, choosing instead to denominate it a "liberty interest."<sup>112</sup> While Rehnquist did not say so explicitly, the clear import of his choice of labels is that the interest involved is not a fundamental right and thus can be subjected to significant state regulation.<sup>113</sup> Finally, while balancing the individual's liberty interest against the State's interest, Rehnquist supported his assertion of the State's strong interest in preserving and protecting

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108. See *Cruzan*, 497 U.S. at 280.

109. See, e.g., Linda Greenhouse, *Justices Find a Right to Die, but the Majority Sees Need for Clear Proof of Intent*, N.Y. TIMES, June 26, 1990, at A1 (stating that eight justices in the *Cruzan* case ruled that a person whose wishes are known has a constitutional right to discontinue life-sustaining treatment); Linda Greenhouse, *Liberty to Reject Life*, N.Y. TIMES, June 27, 1990, at A16 (stating that the Court in *Cruzan* concluded that "the Constitution protects a person's liberty to reject life-sustaining technology"). But see, Kass, *supra* note 107, at 40-41 (arguing that such claims were founded on misinterpretations of the decision).

110. See *Cruzan*, 497 U.S. at 277-78 (Rehnquist, C.J.) ("We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker* . . . where we said that in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'").

111. *Id.* at 279.

112. See *id.* at 279 n.7.

113. See John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139, 1174-75 & n.132 (1991). Both the outcome in the case (upholding the state regulation) and Rehnquist's analysis are far more consistent with rationality review than strict scrutiny. In contrast, Justice Brennan's dissent contends that if a competent person has a liberty interest to be free of unwanted medical treatment, then that interest must be a fundamental one. See *Cruzan*, 497 U.S. at 304-05 (Brennan, J., dissenting). Justice Brennan proceeds to perform strict scrutiny of the State's clear and convincing evidence requirement and concludes that it violates the Due Process Clause of the Fourteenth Amendment. See *id.* at 312-21.

human life by pointing out that the majority of states have laws criminalizing assisted suicide.<sup>114</sup> Furthermore, none of the justices directly refuted Justice Scalia's assertion that "there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.'"<sup>115</sup>

On the other hand, as a counterbalance to the *Cruzan* case and its rather niggardly view of personal liberty in the medical treatment setting, the district court in *Compassion in Dying* could look to the 1992 case of *Planned Parenthood v. Casey*.<sup>116</sup> In that decision, the Supreme Court adopted an "undue burden standard" for determining when state regulation violates a woman's constitutional right to choose to terminate a pregnancy.<sup>117</sup> The jointly authored plurality opinion explained that "[a]n undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."<sup>118</sup> The plurality opinion contained a crucial statement that is at the crux of the plaintiffs' due process arguments in *Compassion in Dying*:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.<sup>119</sup>

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114. See *Cruzan*, 497 U.S. at 280. As Yale Kamisar points out, this language suggests that the majority in *Cruzan* did not view as constitutionally suspect state statutes that criminalize assisted suicide. See Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, 23 HASTINGS CENTER REP., May-June 1993, at 32, 34.

115. *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)). Unlike Justice Scalia, who chose suicide as his paradigm for the *Cruzan* case, the majority chose instead the paradigm of the right to refuse medical treatment. See Kamisar, *supra* note 114, at 34.

116. 505 U.S. 833 (1992). Of course, my characterizations of these cases are relative. If one were to compare the *Casey* case with its predecessor, *Roe v. Wade*, 410 U.S. 113 (1973), one could fairly characterize the *Casey* decision as less generous than *Roe* in its view of personal liberty.

117. See *Casey*, 505 U.S. at 874.

118. *Id.* at 878 (O'Connor, Kennedy, Souter, J.J., joint opinion).

119. *Id.* at 851.

The relevance of *Casey* lay in the possible analogy: if the right of terminally ill, competent individuals to choose assisted death is analogous to a woman's constitutional right to terminate a pregnancy, then state regulation of the "right to die" through euthanasia or assisted suicide may be subject to an undue burden analysis as well. Put differently, the deferential standard of review of state regulation evidenced in *Cruzan* may have been supplanted in *Casey* by a standard more protective of individual liberty. If this is the case, state statutes criminalizing all forms of assisted suicide are now more vulnerable to constitutional attack.<sup>120</sup>

This, then, was the constitutional context for Judge Rothstein's decision for the district court. On cross-motions for summary judgment, she ultimately held the Washington statute unconstitutional on two grounds. First, she found that the statute places an undue burden on the exercise of a Fourteenth Amendment liberty interest accorded the terminally ill who wish to commit physician-assisted suicide.<sup>121</sup> Second, she held that the law violates the right to equal protection under the Fourteenth Amendment by prohibiting physician-

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120. Legal commentators who debated this question prior to the district court's decision reached different conclusions depending on whether they relied on *Cruzan* or *Casey* for support. For example, Professor Kamisar used the *Cruzan* decision to argue that the Court will not in the foreseeable future find a Fourteenth Amendment liberty interest in assisted suicide. See Kamisar, *supra* note 114, at 34. Professor Kass also used *Cruzan* to argue against such a right, but noted that the concurring opinions by Justices O'Connor and Scalia may contain the seeds for "inventing a constitutional right to suicide and . . . assistance with suicide." Kass, *supra* note 107, at 41. He noted that when Scalia's argument (refusal of nutrition and hydration is the equivalent of suicide) is combined with O'Connor's position (the right to refuse nutrition and hydration is already constitutionally protected), one could conclude that a constitutional right to suicide exists. See *id.* Interestingly, neither Kamisar nor Kass made any mention of the *Casey* decision.

In contrast, Professor Robert Sedler used *Casey* to argue that the liberty interest protected by the Due Process Clause is broad enough to include the right of the terminally ill to make decisions to voluntarily end their lives. See Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, 23 HASTINGS CENTER REP., Sept.-Oct. 1993, at 20, 23. He analogized the decision by a terminally ill individual to terminate his or her life to the decision to terminate a pregnancy, arguing that both decisions are based on personal autonomy and protected by the liberty provision of the Due Process Clause. See *id.* at 23. Further, using the *Casey* standard, he contended that the statutes criminalizing assisted suicide place a "substantial obstacle" in the way of the terminally ill who wish to use physician-prescribed medications to hasten their deaths. See *id.* Sedler, of course, omitted any discussion of the *Cruzan* decision in reaching his conclusion.

121. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1467 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom.* *Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110). Her decision is essentially that the ban on assisted suicide is overbroad.

assisted suicide while permitting the withdrawal of life-support systems from terminally ill individuals.<sup>122</sup>

Given this outcome, it is not suprising that Judge Rothstein centered her analysis on *Casey*. The key to the decision is her view that "the suffering of a terminally ill person cannot be deemed any less intimate or personal, or any less deserving of protection from unwarranted governmental interference, than that of a pregnant woman."<sup>123</sup> Having made the connection between the abortion decision and the decision to commit physician-assisted suicide,<sup>124</sup> she held that the latter decision "falls within the realm of the liberties constitutionally protected under the Fourteenth Amendment."<sup>125</sup> Her decision to equate abortion and physician-assisted suicide dictated the result in this case because if *Casey* made anything clear, it was that regulation taking the form of outright prohibition constitutes an undue burden on a protected liberty interest and cannot stand.<sup>126</sup>

Judge Rothstein did not ignore the Supreme Court's decision in *Cruzan*, but her attempts to harmonize it with *Casey* were less than convincing. She acknowledged that Justice Rehnquist's "conclusion" in *Cruzan* that competent individuals have a protected liberty interest in refusing unwanted treatment was "tentative,"<sup>127</sup> but predicted that were it faced squarely with the question, the Supreme Court would reaffirm that conclusion.<sup>128</sup> She further predicted that the Court would not distinguish, as a constitutional matter, between withdrawal of life-sustaining treatment and physician-assisted suicide.<sup>129</sup>

There are two possible critiques of Judge Rothstein's analysis. First, she seemed to assume that all liberty interests are created equal. She thus begged the key constitutional question when she predicted

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122. *See id.* at 1467.

123. *Id.* at 1460.

124. The State argued that the abortion and physician-assisted suicide decisions involved different competing interests. *See id.* Judge Rothstein agreed but concluded that the assisted-suicide decision actually raises less difficult questions because, unlike the abortion decision, only one life is involved, and the individual is capable of expressing his or her wishes. *See id.*

125. *Id.* She states, "The liberty interest protected by the Fourteenth Amendment is the freedom to make choices according to one's individual conscience about those matters which are essential to personal autonomy and basic human dignity." *Id.* at 1461.

126. *See Planned Parenthood v. Casey*, 505 U.S. 833, 877 (1992) (stating that a statute that places a substantial obstacle in the path of a woman's choice is an undue burden).

127. *See Compassion in Dying*, 850 F. Supp. at 1461; *see also supra* notes 109-114 and accompanying text.

128. *See Compassion in Dying*, 850 F. Supp. at 1461.

129. *See id.*



that the Supreme Court would find a "liberty interest" in the decision to commit physician-assisted suicide. The important question is not whether the Court would find a liberty interest, but rather what level of constitutional protection the Court would afford any such liberty interest. If the Court chose to apply the *Cruzan* analysis and level of protection,<sup>130</sup> it could uphold even a total ban on assisted suicide as rationally related to legitimate state objectives.<sup>131</sup> In contrast, if the Court were to apply a *Casey* undue burden analysis, it would likely find a total ban unconstitutional.<sup>132</sup> The second, and related, problem with Judge Rothstein's opinion is that she equated physician-assisted suicide with the long line of cases protecting "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education."<sup>133</sup> In doing so, she ignored the fact that the Supreme Court, in the one instance it was called upon to discuss the parameters of any constitutional right to die,<sup>134</sup> *did not* place that so-called liberty interest within the above line of cases.<sup>135</sup> Instead, when describing the liberty interest in *Cruzan*, the majority cited the case of *Bowers v. Hardwick*,<sup>136</sup> hardly a high-water mark in the jurisprudence of constitutional protection of liberty interests.

The State of Washington ultimately appealed the district court decision<sup>137</sup> and, in a much-anticipated opinion, the Ninth Circuit Court

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130. See *supra* notes 106-115 and accompanying text.

131. The State could legitimately assert a generalized interest in preventing suicide as well as a more particularized interest in protecting the terminally ill from committing suicide under undue influence and duress. See *Compassion in Dying*, 850 F. Supp. at 1464-65.

132. See *supra* note 126 and accompanying text.

133. *Compassion in Dying*, 850 F. Supp. at 1459-60.

134. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990).

135. See Alexander Morgan Capron, *Easing the Passing*, 24 HASTINGS CENTER REP., July-Aug. 1994, at 25 (noting that the Court has repeatedly stressed that the protected liberty interest in those cases is solely the decision to bear or beget children).

136. See *Cruzan*, 497 U.S. at 279 n.7.

137. See *State to Appeal District Court Ruling on Assisted Suicides for Terminally Ill*, 3 Health L. Rep. (BNA) No. 22, at 737-38 (June 2, 1994). During the pendency of the appeal, the medical community expressed uncertainty over the legal status of physician-assisted death in Washington. See Carol M. Ostrom & Susan Gilmore, *Doctors Split on Whether Ruling Gives Them OK to Assist Suicides*, SEATTLE TIMES, May 4, 1994, at A1. The Assistant Attorney General cautioned physicians that anyone who assisted a suicide could be prosecuted later if the law was upheld on appeal, see *id.*, and the Washington State Medical Association and the American Medical Association quickly announced that, despite the Rothstein ruling, physicians who participated in assisted death violated professional ethics standards. See Carol M. Ostrom, *Two Medical Groups Hit Assisted Suicides*, SEATTLE TIMES, May 6, 1994, at B1.

of Appeals reversed.<sup>138</sup> Judge Noonan's majority opinion is remarkable for its relative brevity and clipped, almost derisive, tone. Although the court takes issue with virtually every facet of Judge Rothstein's opinion, two primary themes emerge, relating to the relevant Supreme Court precedent and Washington's interests in prohibiting assisted suicide.

The majority began by challenging the district court's reliance on *Casey*.<sup>139</sup> According to Judge Noonan, the Court's decision in *Casey* was irrelevant to the question at hand, both because abortion is sui generis and because there are significant "differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request."<sup>140</sup> The court was clearly concerned that if it were to find a constitutional right to assisted suicide in this case, it would be unable in the future to limit that right to the terminally ill.<sup>141</sup> To avoid this result, which Judge Noonan termed "*reductio ad absurdum*,"<sup>142</sup> the circuit court looked to *Cruzan* as the guiding Supreme Court precedent.<sup>143</sup> Whereas Judge Rothstein emphasized the Court's willingness in *Cruzan* to posit a competent individual's constitutional right to refuse unwanted medical treatment,<sup>144</sup> the Ninth Circuit found determinative the Court's willingness in *Cruzan* to distinguish between the withdrawal of life support and assisted suicide.<sup>145</sup> Having found that the district court decision lacked foundation in recent precedent, and noting that no court of final jurisdiction in this country has ever upheld a

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138. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir.), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom. Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110). Judges Noonan and O'Scannlain made up the majority while Judge Wright dissented.

139. *See id.* at 590.

140. *Id.*

141. *See id.* at 591. Judge Noonan referred to the category of terminally ill persons as "inherently unstable." *Id.* at 590. *But see id.* at 594-95 (Wright, J., dissenting) (arguing that the court is not now called upon to define the parameters of the right).

142. *Id.* at 591.

143. "While *Casey* was not about suicide at all, *Cruzan* was about the termination of life." *Id.*

144. *See Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1461 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom. Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110). Judge Rothstein then extrapolated the right to assisted suicide for the terminally ill from the right to refuse life-sustaining treatment. *See id.*

145. *See Compassion in Dying*, 49 F.3d at 591 (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 280 (1990)).

constitutional right to assisted suicide,<sup>146</sup> Judge Noonan concluded this portion of the opinion in ringing fashion by declaring that "a federal court should not invent a constitutional right unknown to the past and antithetical to the defense of human life."<sup>147</sup>

The appellate court next shifted its focus from whether individuals have a liberty interest in assisted suicide to an analysis of Washington's interest in prohibiting such activities. The court briefly identified five state interests<sup>148</sup> to which Judge Rothstein gave insufficient consideration: (1) the interest in not having physicians in the role of killers of their patients,<sup>149</sup> (2) the interest in protecting the elderly and infirm from psychological pressure to consent to their own deaths,<sup>150</sup> (3) the interest in protecting minorities and the poor from exploitation,<sup>151</sup> (4) the interest in protecting the handicapped from societal indifference and antipathy,<sup>152</sup> and (5) the interest in preventing abuses such as have occurred in the Netherlands.<sup>153</sup> While the interests were listed separately, the latter four are all concerned with the state's interest in protecting individuals who are vulnerable (through socioeconomic status, racial classification, advanced age, or disability) from coerced or involuntary assisted suicide. Because the court had earlier in the opinion rejected the notion of a fundamental right to assisted suicide, it easily concluded that these state interests are sufficient to justify Washington's statutory ban.<sup>154</sup>

As so often happens in constitutional jurisprudence, the way in which the court characterizes the right in question goes a long way toward determining the result. The majority spoke of a right to assisted suicide and found none, while Judge Wright in dissent spoke of a right to self-determination and privacy regarding personal decisions and located this right within American history and

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146. *See id.*

147. *Id.*

148. The court actually listed seven state interests but the last two are less state interests than they are additional critiques of the district court opinion. *See id.* at 592-94 (questioning the indefinite scope of the district court judgment and the lower court's refusal to recognize the difference between withdrawal of life support and assisted suicide).

149. *See id.* at 592.

150. *See id.*

151. *See id.*

152. *See id.*

153. *See id.* at 593.

154. *See id.* at 591. Because the court did not find a fundamental right to assisted suicide, it subjected the Washington regulation to deferential rationality review. *See id.* at 593-94 (stating that the statute must be upheld unless the plaintiffs show that the legislature's actions were irrational).

traditions.<sup>155</sup> He countered the majority's assertion that the relevant language in *Casey* must be confined to the abortion context,<sup>156</sup> and, in fact, went beyond *Casey* by arguing for strict scrutiny of any state regulation of a terminally ill, competent individual's fundamental privacy right to choose physician-assisted death.<sup>157</sup> As to the issue of the State's interest in protecting vulnerable citizens, Judge Wright evinced confidence in the Washington Legislature's ability to enact sufficiently protective regulations.<sup>158</sup>

Buoyed by Judge Wright's dissent, the plaintiffs petitioned the Ninth Circuit for rehearing en banc. In an interesting twist, a majority of the circuit judges voted to grant the plaintiffs' petition.<sup>159</sup> On March 6, 1996, the en banc panel, by an eight-to-three vote, repudiated the original appellate decision by affirming Judge Rothstein and striking down Washington's statute under the Due Process Clause of the Fourteenth Amendment.<sup>160</sup>

The majority opinion, authored by Judge Stephen Reinhardt, is a sweeping exploration of the historical, societal, and legal implications of physician-assisted suicide. The court first examined whether "a liberty interest exists in determining the time and manner of one's death," and found the similarities between the right-to-die cases and the abortion cases to be compelling.<sup>161</sup> In an interesting jurisprudential maneuver, the Ninth Circuit refused to categorize the liberty interest in hastening one's death as either a fundamental right requiring strict scrutiny, or a mere liberty interest requiring only rational basis

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155. *See id.* at 596 (Wright, J., dissenting). Judge Wright asserted that when analyzing whether American tradition and history support the right in question, the court must conduct the inquiry at a more abstract level than the majority does in order to account for the evolution of medicine and the correspondingly new legal questions. *See id.*

156. *See id.* at 595 (stating that the language in *Casey* was derived from a long line of Supreme Court decisions).

157. *See id.* Judge Wright rejected the undue-burden standard applied by the district court because, in his view, *Casey* did not discard the traditional strict scrutiny test in fundamental-rights cases not involving abortion. *See id.* at 596 n.6.

158. *See id.* at 597.

159. *See* *Compassion in Dying v. Washington*, 62 F.3d 299 (9th Cir. 1995). Under the federal appellate rules, a majority vote of the active circuit court judges is required for a rehearing en banc. *See* FED. R. APP. P. 35(a). By circuit rule, the Ninth Circuit en banc court is a limited one, consisting of the Chief Judge and ten additional active circuit judges chosen by lot. *See* 9TH CIR. R. 35-3.

160. *See* *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom.* *Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110).

161. *Id.* at 800. The court explicitly rejected the "suicide" terminology and instead explored whether an individual has a liberty interest in hastening one's own death or determining the time and manner of death. *See id.* at 802.

review.<sup>162</sup> The court argued that the Supreme Court's substantive due process cases have moved away from the "artificial" two- or three-tier level of scrutiny analysis toward a continuum approach in which the more important the individual's right, the stronger the required justification from the State for infringing on that right.<sup>163</sup> The court concluded that, although there might be legitimate disagreement over whether the liberty interest to hasten one's own death is a fundamental right, or simply an important interest subject to a balancing test, no one can legitimately argue that rational basis review is appropriate.<sup>164</sup>

Judge Reinhardt's opinion then moved to an examination of the existence and strength of the liberty interest in question. The court explicitly rejected a purely historical approach, arguing that the route chosen by the original three-judge panel had been foreclosed by *Casey*.<sup>165</sup> Furthermore, the majority asserted that historical attitudes toward suicide have evolved over time to the point that most Americans now support allowing the terminally ill to hasten their deaths and relieve their suffering through the withdrawal of life-sustaining treatment or the administration of lethal doses of medication.<sup>166</sup>

The Ninth Circuit found additional support for a constitutional right to choose the timing and manner of one's own death in *Casey*<sup>167</sup> and *Cruzan*.<sup>168</sup> Quoting the critical language from *Casey*, which defines the intimate and personal choices protected by the Due Process Clause,<sup>169</sup> and analogizing the decision to end one's life to a woman's decision to terminate a pregnancy, the court found that a competent, terminally ill adult has a strong liberty interest in choosing to hasten his or her own death.<sup>170</sup> The court also used the *Cruzan* decision to support its conclusion, arguing that the Court's recognition in *Cruzan* of the right to refuse artificial nutrition and hydration was necessarily a recognition of a liberty interest in hastening death.<sup>171</sup>

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162. See *id.* at 804-05.

163. See *id.* at 803-04.

164. See *id.* at 804.

165. See *id.* at 805-06 (quoting *Planned Parenthood v. Casey*, 505 U.S. 833, 847-49 (1992)).

166. See *id.* at 806-10.

167. 505 U.S. at 833.

168. 497 U.S. 261 (1990).

169. See *supra* note 119 and accompanying text.

170. See *Compassion in Dying*, 79 F.3d at 813-14.

171. See *id.* at 814-16.

Having explored the origins and strength of the liberty interest in question, the opinion turned to a balancing of the State's competing interests in banning physician-assisted suicide. It is here that the differences between the three-judge panel's decision and the en banc decision are most apparent. While recognizing Washington's legitimate interest in preserving life, the en banc opinion asserted that the state's interests are dramatically reduced in the case of terminally ill individuals who wish to die.<sup>172</sup> Judge Reinhardt argued that, in fact, Washington has already conceded as much through its common law and the enactment of a Natural Death Act that acknowledges and effectuates the rights of adult persons to refuse treatment, including the right of terminally ill or permanently unconscious individuals to refuse or withdraw life-sustaining treatment through living wills and durable powers of attorney.<sup>173</sup> The court stated: "In light of [these common-law and statutory developments], opponents of physician-assisted suicide must now explain precisely what it is about the physician's conduct in assisted suicide cases that distinguishes it from the conduct that the state has explicitly authorized."<sup>174</sup> Thus, the key to the Ninth Circuit decision is the majority's view that no ethical or constitutional difference exists between a physician pulling the plug on a ventilator and a physician writing a prescription so that a terminally ill individual can end her own life.<sup>175</sup> In fact, the court even questioned whether the latter should be classified as "suicide."<sup>176</sup>

Having equated the various forms of "hastening death," the majority summarily rejected the contention that legalization of physician-assisted death will lead to exploitation of the poor and minorities. The court labeled this contention "disingenuous" and "fallacious,"<sup>177</sup> and in doing so, appeared to understate the very real risks that numerous commentators, even those in favor of physician-assisted death, have recognized. Finally, in its analysis of possible state interests in banning assisted suicide, the court rejected the view that allowing physicians to assist in suicides would threaten the integrity of the medical profession. The court again built on the

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172. *See id.* at 820.

173. *See id.* at 817-18 (quoting WASH. REV. CODE ANN. § 70.122.010 (West 1992 & Supp. 1996)).

174. *Id.* at 822.

175. *See id.* at 824. The court states that no valid legal foundation exists for drawing a distinction on the basis of whether the individual's death results from the underlying disease or from a lethal dose of medication. *See id.* at 822.

176. *See id.* at 824.

177. *Id.* at 825.

premise that, through the withdrawal of life-sustaining treatment and the administration of pain medications that can themselves cause death, physicians already hasten their patients' deaths in ways that cannot be distinguished from physician-assisted suicide.<sup>178</sup>

The Ninth Circuit thus concluded that when a mentally competent, terminally ill individual wishes to hasten his death, that person's liberty interest is at its height and the State's interest in preserving the individual's life is at its nadir.<sup>179</sup> Given this, the balancing of interests required under a substantive due process analysis weighs heavily in favor of the individual, leading to the conclusion that Washington's ban on assisted suicide is unconstitutional as applied to terminally ill, competent individuals who wish to hasten their deaths with prescription medication.<sup>180</sup> In reaching this conclusion, the court acknowledged that additional questions are raised, such as whether a state can constitutionally prevent the non-terminally ill from using physician-assisted suicide, and whether a state can constitutionally limit assisted suicide to the writing of a prescription, as opposed to the administration of a lethal injection.<sup>181</sup> The court, not surprisingly, left those questions for another day but hinted that it might draw the line between voluntary and involuntary termination of a person's life.<sup>182</sup> This of course signals the very real possibility of future judicial expansion of the constitutional right to die.

In contrast to the majority opinion, the primary dissenting opinion, authored by Judge Beezer,<sup>183</sup> took a traditional due process approach to the question and concluded that mentally competent, terminally ill individuals do not have a fundamental right to physician-assisted suicide.<sup>184</sup> He applied a rational basis test to Washington's

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178. *See id.* at 828-29.

179. *See id.* at 837.

180. *See id.*

181. *See id.* at 831. The court also discusses the *Lee v. Oregon* case and states that Judge Hogan erred in declaring Oregon's statute to be unconstitutional. *See id.* at 837-38; *see also supra* note 86 (discussing the procedural history of *Lee* in the Ninth Circuit and the clear error involved in Judge Hogan's analysis).

182. *See id.* at 831-32 (Beezer, J., dissenting).

183. Judge Fernandez joined Judge Beezer's dissent with the caveat that Fernandez did not find even a nonfundamental liberty interest in assisted suicide in the Constitution. *See id.* at 857. Judge Kleinfeld joined Judge Beezer's dissent with two caveats: he doubted the existence of any constitutional protection for assisted suicide and he would go further than Judge Beezer in denouncing the majority's view that there is no constitutional or ethical difference between the provision of medication for pain relief and the provision of medication to cause death. *See id.* at 857-58.

184. *See id.* at 845-49.

statute and found that the State has sufficiently legitimate interests in preserving life and preventing suicide to justify its ban on assisted suicide.<sup>185</sup>

Following the announcement of the Ninth Circuit's decision in *Compassion in Dying*, the State of Washington quickly announced that it would petition the Supreme Court for review.<sup>186</sup> The certiorari petition was delayed, however, by a request from the court that the parties submit briefs addressing whether the entire twenty-five-judge court should rehear the case.<sup>187</sup> The court ultimately denied further review,<sup>188</sup> clearing the way for an appeal to the Supreme Court.

### 3. New York

The Ninth Circuit is not alone in its consideration of the thorny issue of physician-assisted death. Much has occurred in other venues in which this battle is being fought. Shortly after Judge Rothstein's decision in Washington, three terminally ill patients and their physicians<sup>189</sup> filed suit in federal district court in Manhattan seeking to have New York's criminal prohibition on assisted suicide declared unconstitutional.<sup>190</sup> The lawsuit was filed, in part, to counteract an influential 1994 report by the New York State Task Force on Life and the Law, which recommended against legalizing physician-assisted suicide in New York by a unanimous vote of its twenty-four members.<sup>191</sup> That the facts and legal issues raised in *Quill v. Koppell*<sup>192</sup>

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185. See *id.* at 851-55. He similarly finds that the statute survives equal protection analysis because the state may rationally distinguish between death through the withdrawal of life-sustaining treatment and death by prescription medication. See *id.* at 856-57.

186. See 5 Health L. Rep. (BNA) No. 13, at 479 (Mar. 28, 1996).

187. See Carol M. Ostrom, *Suicide Issue May Be Reheard—9th Circuit Asks for Briefs in Case*, SEATTLE TIMES, Mar. 28, 1996, at B3. A judge or judges on the Ninth Circuit evidently made the request. See *id.*

188. See *Assisted-Suicide Ruling Blocked*, SEATTLE TIMES, May 30, 1996, at B2.

189. One of the physician plaintiffs is Dr. Timothy Quill. For a discussion of Dr. Quill's experience with physician-assisted suicide, see *infra* Part III.A.4.

190. See Ronald Sullivan, *Suit Challenges New York's Law Banning Doctor-Assisted Suicide*, N.Y. TIMES, July 22, 1994, at B3.

191. See Timothy E. Quill, *The Care of Last Resort*, N.Y. TIMES, July 23, 1994, at 9; see also *Compassion in Dying v. Washington*, 49 F.3d 586, 591-92 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom. Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110) (describing the genesis of the Task Force and its composition); Elisabeth Rosenthal, *Panel Tells Albany to Resist Legalizing Assisted Suicide*, N.Y. TIMES, May 26, 1994, at A1. The task force, which reported to Governor Cuomo, concluded that legalized assisted suicide would benefit a few individuals but that the risk of widespread abuse outweighed any benefits. See Rosenthal, *supra*, at A1.

192. 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, 64 U.S.L.W. 3795 (U.S. Oct. 1, 1996) (No. 95-1858).



are virtually identical to those of *Compassion in Dying* is not surprising given that the Compassion in Dying Organization funded the New York challenge and the same attorney represented the plaintiffs in both actions.<sup>193</sup> The only significant difference at the district court level was the outcome.

Chief Judge Griesa's opinion in *Quill* reads like a mirror image of Judge Rothstein's in *Compassion in Dying*. Where she found a constitutionally protected right to assisted suicide,<sup>194</sup> he found a long tradition of state criminalization of such activities.<sup>195</sup> Where she found *Casey* to be practically prescriptive on the question,<sup>196</sup> he read *Casey* to be limited to abortion rights cases.<sup>197</sup> Where she found a violation of equal protection,<sup>198</sup> he found a rational basis for states to distinguish between the refusal of life-sustaining treatment and physician-assisted suicide.<sup>199</sup>

After a lengthy delay, the Second Circuit Court of Appeals this year issued its opinion in the *Quill* case, holding New York's statute to be unconstitutional to the extent that it prohibits a physician from prescribing a lethal dose of medication to competent, terminally ill individuals.<sup>200</sup> But the Second Circuit's reasoning differed significantly from both Judge Rothstein's and the Ninth Circuit's en banc opinions in *Compassion in Dying*. The opinion, written by Judge Miner and joined by Judge Pollack,<sup>201</sup> explicitly rejected the notion that individuals have a fundamental constitutional right to assisted suicide. The court noted that the Supreme Court has been reluctant to expand the list of fundamental substantive due process rights, and concluded

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193. See *id.*

194. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1462 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom. Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110).

195. See *Quill*, 870 F. Supp. at 83-84.

196. See *Compassion in Dying*, 850 F. Supp. at 1459.

197. See *Quill*, 870 F. Supp. at 83.

198. See *Compassion in Dying*, 850 F. Supp. at 1467.

199. See *Quill*, 870 F. Supp. at 84-85.

200. See *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, 64 U.S.L.W. 3795 (U.S. Oct. 1, 1996) (No. 95-1858).

201. Judge Guido Calabresi concurred in the result but wrote separately to explain his reasoning. See *id.* at 731 (Calabresi, J., concurring). Judge Calabresi took the position that New York's statute is constitutionally suspect under both due process and equal protection analysis but that it is not clearly invalid. See *id.* at 738. He would therefore strike down the statute while leaving open the possibility of reconsideration if the state were to come forward with current and clearly expressed policy statements in support of the statutory ban on assisted suicide. See *id.*

that a right to assisted suicide is neither implicit in the concept of ordered liberty nor deeply rooted in our country's traditions and history.<sup>202</sup>

Instead, the Second Circuit grounded its holding in equal protection. Because the court viewed New York's statute as falling within the category of social-welfare legislation, it subjected the statutory ban to rational basis scrutiny.<sup>203</sup> Despite the deferential nature of this standard of review, the court found the statute to be constitutionally infirm by comparing the different ways in which the state treats the terminally ill who wish to die by withdrawing life-sustaining treatment and those who wish to die through the use of prescription medication. In the case of the former, New York allows individuals to refuse or withdraw life support under common-law authority as well as statutory authority providing for Do-Not-Resuscitate (DNR) orders and the appointment of health care proxies.<sup>204</sup> In contrast, New York's statute criminalizing assistance in suicide effectively prevents terminally ill individuals who are not dependent on life support from similarly hastening their deaths through the use of prescription drugs.<sup>205</sup> Having found that the State treats similarly situated groups of people differently, the court went on to conclude that the different treatment is not rationally related to any legitimate state interest.<sup>206</sup> In the court's view, the State cannot rationally take a greater interest in preserving the lives of one group as compared to the other. In addition, physicians are not fulfilling the role of "killer" by prescribing drugs to hasten death any more than they are by disconnecting life-sustaining treatment. Furthermore, the risks of psychological pressure and undue influence are not higher in one group as opposed to the other.<sup>207</sup> In effect, the court concluded that one form of hastening death is equivalent to the other;<sup>208</sup> therefore, the State cannot authorize one and prohibit the other, particularly when doing so operates to the detriment of a similarly situated group of terminally ill individuals.

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202. *See id.* at 723-25.

203. *See id.* at 726-27.

204. *See id.* at 727-28.

205. *See id.* at 729.

206. *See id.*

207. *See id.* at 729-30.

208. The Second Circuit took the view that death by the withdrawal of life-sustaining treatment and death by prescription medication are both artificial—neither comes about as the natural result of the patient's disease. *See id.* at 729.

The constitutional landscape on the issue of physician-assisted death has become increasingly complex. The various courts that have taken up the issue have applied virtually every possible mode of constitutional analysis and have reached varied conclusions. For example, in taking the position that a complete ban on assisted suicide is unconstitutional, Judge Rothstein applied *Casey's* undue-burden analysis and found a substantive due process violation;<sup>209</sup> the Ninth Circuit, sitting en banc, applied a "continuum" and balancing analysis and found a substantive due process violation;<sup>210</sup> the Second Circuit applied a traditional analysis and found no substantive due process violation but did find an equal protection violation under rational basis review;<sup>211</sup> and Judge Wright of the original Ninth Circuit panel found a fundamental right and used strict scrutiny to strike the statute.<sup>212</sup> On the other hand, in taking the position that such bans do not violate the Constitution, Judge Griesa applied traditional Fourteenth Amendment analysis and found no substantive due process or equal protection violations,<sup>213</sup> as did the majority in the original Ninth Circuit panel, the dissents in the Ninth Circuit en banc decision, and the majority in the Michigan Supreme Court decision.<sup>214</sup>

Perhaps the confusion over the proper mode of constitutional analysis is not all that surprising. The proper choice among *Cruzan's* liberty-interest with rationality review analysis, *Casey's* undue-burden standard, traditional fundamental-rights analysis with strict scrutiny, or something in between is neither easy nor obvious. The answer likely turns on the extent to which the Supreme Court's opinion in *Casey* signaled a fundamental shift in substantive due process jurisprudence generally, as opposed to a constitutional middle ground intended for the issue of abortion alone. Regardless, the stage was clearly set for

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209. See *Compassion in Dying v. Washington*, 850 F. Supp. 1454, 1464-65 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom.* *Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110).

210. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom.* *Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110).

211. See *Quill*, 80 F.3d at 716.

212. See *Compassion in Dying v. Washington*, 79 F.3d at 790.

213. See *Quill v. Koppell*, 870 F. Supp. 78, 82-84 (S.D.N.Y. 1994), *rev'd sub nom.* *Quill v. Vacco*, 80 F.3d 176 (2d Cir.), *cert. granted*, 64 U.S.L.W. 3795 (U.S. Oct. 1, 1996) (No. 95-1858).

214. See *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995); *Compassion in Dying*, 79 F.3d at 790; *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995).

Supreme Court review, and on October 1, 1996, the Court granted certiorari in both the *Compassion in Dying* and *Quill* cases.<sup>215</sup> The direction the Court takes in deciding whether terminally ill individuals have a constitutionally protected right to physician-assisted death may determine the course of substantive due process analysis for years to come.<sup>216</sup>

It is thus almost impossible to overstate the importance of the pending constitutional challenges to statutes that legalize or criminalize physician-assisted death. Yet, having said that, I propose to leave the reading of the Supreme Court tea leaves to others,<sup>217</sup> and move on to an issue that has received less attention but is no less important. Whatever the outcome of the pending litigation, one thing is clear: the Supreme Court will be asked to consider the question of assisted death in a medical context, and physicians and the medical profession will figure prominently in the ultimate decision. The remainder of this Article is devoted to an exploration of the significance of physician involvement in assisted death—for physicians and for society.

### III. THE PHYSICIAN'S ROLE: THE MEDICAL PERSPECTIVE

The current climate is in a tremendous state of flux. Virtually every state in the union is dealing with the issue of physician-assisted death, either through legislative bills designed to criminalize or legalize these activities; grassroots initiatives such as Initiative 119,<sup>218</sup>

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215. See *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), cert. granted sub nom. *Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110); *Quill v. Vacco*, 80 F.3d 176 (2d Cir. 1996), cert. granted, 64 U.S.L.W. 3795 (U.S. Oct. 1, 1996) (No. 95-1858).

216. The probable outcome is difficult to predict, particularly given the dramatic change in the makeup of the Supreme Court over the last four years. Since the 5-4 decision in *Cruzan* in 1990, Justices Brennan, Marshall, White, and Blackmun have retired and Justices Souter, Thomas, Ginsburg, and Breyer have joined the Court.

217. See, e.g., Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 NOTRE DAME L. REV. 519, 545-80 (1995); Carl H. Coleman & Tracy E. Miller, *Stemming the Tide: Assisted Suicide and the Constitution*, 23 J.L. MED. & ETHICS 389 (1995); Kreimer, *supra* note 3; Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 SEATTLE U. L. REV. 509 (1995); Kathryn L. Tucker & David J. Burman, *Physician Aid in Dying: A Humane Option, a Constitutionally Protected Choice*, 18 SEATTLE U. L. REV. 495 (1995); Willard C. Shih, Note, *Assisted Suicide, the Due Process Clause and "Fidelity in Translation,"* 63 FORDHAM L. REV. 1245 (1995).

218. See Initiative 119.

Proposition 161,<sup>219</sup> and Ballot Measure 16;<sup>220</sup> task forces and commissions called upon to study the issue; or court challenges to the constitutionality of assisted-suicide statutes. Despite the rapidly changing legal and societal landscape, however, there is one constant. Every public debate over assisted death—every initiative, proposition, legislative bill, task force recommendation, and court decision—operates under the singular assumption that physicians and the medical profession are the only possible providers of this “service.”

Even the way commentators discuss assisted death reflects this assumption. In years past, scholars on the subject wrote and spoke of “voluntary euthanasia.” That term is rapidly being replaced with the phrase “*physician-assisted suicide*.” This shift in rhetoric to emphasize physician involvement is neither accidental nor insignificant. It is symbolic of the fact that we can no longer imagine assisted death outside of a medical context. One way to explore this “medicalization” of assisted death is to view it through the eyes of the medical profession.

#### A. *Defining Events in Medicine*

“I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.”<sup>221</sup> These words have survived to the present day as part of the Oath of Hippocrates, the starting point for every medical ethics code written since.<sup>222</sup> Those who invoke the Oath of Hippocrates on this issue usually do so to emphasize that the prohibition against physician-assisted suicide and euthanasia has stood for thousands of years.<sup>223</sup> But because a number of the Oath’s mandates have not been carried forward into present day codes, and are in fact disregarded by the profession,<sup>224</sup> attempts to use the Oath as

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219. See Proposition 161.

220. See ORE. REV. STAT. §§ 127.800-.895 (1995).

221. LUDWIG EDELSTEIN, *THE HIPPOCRATIC OATH: TEXT, TRANSLATION, AND INTERPRETATION* 3 (Henry Sigerist ed., 1943).

222. See Ben A. Rich, *Postmodern Medicine: Deconstructing the Hippocratic Oath*, 65 U. COLO. L. REV. 77, 86 & n.48 (1993). Several historians have taken the position that the Oath was not the product of the Greek physician Hippocrates but rather was written by members of the Pythagorean cult sometime after Hippocrates’ death. See *id.* at 88. They argue that the proscriptions against euthanasia and abortion are inconsistent with the prevailing attitudes among physicians and the public at the time of Hippocrates. See *id.*

223. See, e.g., Orentlicher, *supra* note 2, at 1844 (stating that the prohibition against assisting in patients’ deaths has been with us “from the time of Hippocrates”).

224. For example, many physicians do not comply with the extensive filial and financial obligations toward fellow medical practitioners and the covenants to refrain from performing abortions and surgery that are set out in the Hippocratic Oath. See EDELSTEIN,

binding authority on the issues of physician-assisted suicide and euthanasia are problematic. Proponents of assisted death have gone so far as to argue that the Hippocratic Oath is anachronistic and of little relevance to the practice of medicine today.<sup>225</sup> As a result, much of the debate within the profession over physician-assisted suicide revolves more around current conceptions of the healing role than around the literal words of Hippocrates.<sup>226</sup>

Physicians form their attitudes and opinions about such issues as assisted death within the discourse of the medical profession. As a group, they are "professionalized" to respond to individuals within the ranks and to resist demands from those outside. It is thus not surprising that for years the organized profession held fast to its position against euthanasia<sup>227</sup> and ignored entreaties by Derek Humphry and the Hemlock Society for physicians to take an active role in helping their patients achieve "dignified" deaths. It was only when physicians themselves began to question the healer's role and rethink the issue of assisted death that the medical profession as a whole finally entered into the public discourse on physician-assisted suicide and euthanasia. The defining events in this process of reevaluation are recorded in the pages of the preeminent medical journals, where physicians have described their own experiences with

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*supra* note 221, at 3. The only provisions of the Oath that appear in all modern codes of medical professional responsibility are the prohibitions against having sexual relations with patients and those against disclosing patient confidences. See Rich, *supra* note 222, at 90.

225. See, e.g., Richard L. Brown, *Euthanasia Debate [Letter]*, 323 JAMA 1771, 1771-72 (1990) (arguing that the medical profession's resistance to euthanasia reflects the anachronistic values of the Hippocratic Oath); Herbert S. Gross, *Euthanasia Debate [Letter]*, 323 JAMA 1770 (1990) (stating that the distinction between healing and killing that was clear to Hippocrates is anachronistic).

226. Dr. Thomas Preston persuasively argues that physicians' perceptions of their proper roles are based more on professional training and socialization than they are on professional codes of ethics. See Thomas A. Preston, *Professional Norms and Physician Attitudes*, 22 J.L. MED. & ETHICS 36, 39 (1994). He contends, moreover, that medical codes of ethics have historically reflected self-serving professional interests rather than patients' interests, making them poor guides for present-day discussions of medical ethics. See *id.*

227. The American Medical Association (AMA) has historically taken a position against euthanasia and physician-assisted suicide. Despite the current debate, the AMA's position has not changed. See COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS §§ 2.21, 2.211 (1994) (stating that physicians should not engage in euthanasia or physician-assisted suicide, but rather should provide dying patients with emotional support, comfort care, and pain control); Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229, 2233 (1992) (stating that "[p]hysicians must not perform euthanasia or participate in assisted suicide").

assisted death and their colleagues have responded, provoking a vigorous debate.

1. "It's Over, Debbie"

The first in this series of reevaluations was an account written by an anonymous gynecology resident and published in the *Journal of the American Medical Association* in 1988. In condensed form, the author told the following story:

The call came in the middle of the night. As a gynecology resident rotating through a large, private hospital, I had come to detest telephone calls, because invariably I would be up for several hours and would not feel good the next day. However, duty called, so I answered the phone. A nurse informed me that a patient was having difficulty getting rest, could I please see her. . . .

I grabbed the chart from the nurses station on my way to the patient's room, and the nurse gave me some hurried details: a twenty-year-old girl named Debbie was dying of ovarian cancer. . . . Hmmmm, I thought. Very sad. As I approached the room I could hear loud, labored breathing. I entered and saw an emaciated, dark-haired woman who appeared much older than twenty. . . . The room seemed filled with the patient's desperate effort to survive. Her eyes were hollow, and she had suprasternal and intercostal retractions with her rapid inspirations. She had not eaten or slept in two days. . . . It was a gallows scene, a cruel mockery of her youth and unfulfilled potential. Her only words to me were, "Let's get this over with."

I retreated with my thoughts to the nurses station. The patient was tired and needed rest. I could not give her health, but I could give her rest. I asked the nurse to draw 20 mg of morphine sulfate into a syringe. Enough, I thought, to do the job. I took the syringe into the room . . . . Debbie looked at the syringe, then laid her head on the pillow with her eyes open, watching what was left of the world. I injected the morphine intravenously and watched to see if my calculations on its effects would be correct. Within seconds her breathing slowed to a normal rate, her eyes closed, and her features softened as she seemed restful at last. . . . I waited for the inevitable next effect of depressing the respiratory drive. With clocklike certainty, within four minutes the breathing slowed even more, then became irregular, then ceased. . . .

It's over, Debbie.<sup>228</sup>

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228. *It's Over, Debbie*, 259 JAMA 272 (1988).

The medical profession's reaction to this account was swift and extremely critical.<sup>229</sup> In a scathing commentary, several well-known physicians and academicians condemned the resident's actions as criminal, unprofessional, and unethical.<sup>230</sup> Their criticism centered first on the way in which the act was done. The resident had never seen or conversed with this patient before, had not studied her chart, or spoken with her attending physician or family.<sup>231</sup> To make matters worse, the physician did not talk with the patient or ask her to explain her ambiguous statement, but instead interpreted her words as a plea for death and then acted upon those words seemingly without hesitation.<sup>232</sup> The commentators labeled the resident "an impulsive yet cold technician, arrogantly masquerading as a knight of compassion and humanity."<sup>233</sup>

Some physician commentators saw this incident as much more than an isolated illegal and unethical act by a member of the profession. In their view, the resident's actions and the *Journal of the American Medical Association's* willingness to publish the story without editorial criticism or comment put "[t]he very soul of medicine . . . on trial."<sup>234</sup> They argued that the moral center of medicine, the ethical canon that "doctors must not kill," was at stake,<sup>235</sup> and they urged physicians to take up the gauntlet by proclaiming to society that

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229. Early responsive letters from physicians to the *Journal of the American Medical Association* ran against the actions of the resident by a ratio of four to one, but later letters ran strongly in favor. See George D. Lundberg, 'It's Over, Debbie' and the Euthanasia Debate, 259 JAMA 2142, 2142 (1988).

230. See Willard Gaylin et al., 'Doctors Must Not Kill,' 259 JAMA 2139, 2139 (1988).

231. See *id.*

232. See *id.* The resident appeared to assume that he or she had given a lethal dose of morphine that would inevitably cause the patient's death. One physician attempted to justify the resident's actions by suggesting that 20 mg of morphine is not unquestionably a lethal dose so that the resident may have been attempting to relieve pain rather than kill. See Kenneth L. Vaux, *Debbie's Dying: Mercy Killing and the Good Death*, 259 JAMA 2140, 2140 (1988).

233. Gaylin et al., *supra* note 230, at 2139.

234. *Id.* They roundly criticized the *Journal's* editor for shielding the author from criminal action by withholding his or her name. See *id.* The editorial staff responded by arguing that publication was appropriate in order to provoke responsible debate over euthanasia within the profession and society. See Lundberg, *supra* note 229, at 2142.

235. See Gaylin et al., *supra* note 230, at 2140. According to the authors, Western medicine since Hippocrates' time has regarded the intentional killing of patients, even with their consent, as a violation of one of the fundamental canons of the medical profession. See *id.* at 2139.



if it chose to tolerate euthanasia, "it [would] have to find nonphysicians to do its killing."<sup>236</sup>

Other responses were more subdued, condemning this particular act but questioning whether there might not be a role for assisted suicide or euthanasia under different circumstances. For example, one bioethicist argued that throughout the centuries of medical practice, an allowance for "exceptional-case" active euthanasia for the relief of suffering has existed alongside the principle proscribing such actions.<sup>237</sup>

## 2. The Council of Twelve

The next defining event occurred in 1989 when a group of twelve highly respected physicians, brought together by the Society for the Right to Die, produced a report on physicians' responsibility toward "hopelessly ill patients."<sup>238</sup> The authors intended the report to provide a comprehensive examination of current clinical practices affecting the care of dying patients; physician-assisted suicide and euthanasia were but two of many topics they took up.<sup>239</sup> In the course of their discussion, the physicians drew two immensely important conclusions. First, they agreed that under certain rare circumstances, a terminally ill patient's wish to end his or her life may be rational.<sup>240</sup> Second, a majority of the physicians concluded that it was "not immoral" for a physician to assist a rational, terminally ill person in committing suicide.<sup>241</sup> As they explained in a subsequent editorial letter, the

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236. *Id.* at 2140.

237. *See* Vaux, *supra* note 232, at 2141.

238. *See* Wanzer et al., *supra* note 1. This same group of twelve wrote a report five years earlier on the same subject. *See* Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955 (1984).

239. Among the other subjects covered were the importance of discussions between physicians and their patients about the dying process, the utility of advance directives in directing care, the need to better educate medical students and residents in the care of the dying, the ways in which pain control for the terminally ill could be improved, and possible settings for death such as home, nursing home, and hospital. *See* Wanzer et al., *supra* note 1, at 844-47.

240. *See id.* at 848. According to the authors, proper care at the end of life should make the desire to commit suicide rare. *See id.* at 847. Their vision of a rational suicide is one in which the terminally ill individual does not suffer from a treatable depression and where health-care providers and family have done everything possible to relieve the individual's pain and distress, and yet the person still perceives the situation as intolerable and seeks to die. *See id.* at 847-48.

241. *See id.* at 848. Ten of the twelve physicians took this position. *See id.* The report also discusses euthanasia, in which the physician would perform the final act that causes death, but the authors did not take a position on the morality of such conduct. *See id.*

choice of the "not immoral" language was deliberate because the authors could not agree that such actions could be described as "ethical."<sup>242</sup>

Even though the authors had intended to stimulate discussion on a broad range of issues related to the care of the dying, almost all of the readers who responded spoke exclusively to the issues of physician-assisted suicide and euthanasia.<sup>243</sup> One individual, despite disagreeing with the authors' position, called the article "a landmark that clearly identifies a change in physicians' attitudes toward the helplessly sick."<sup>244</sup> The American Medical Association responded with a position paper justifying the longstanding medical tradition (and the American Medical Association position) against physician-assisted suicide and euthanasia, arguing that such actions are fundamentally inconsistent with physicians' primary role as healers.<sup>245</sup>

### 3. Jack Kevorkian

At about the time that physicians as a group were beginning to seriously grapple with the professional and societal questions posed by assisted death, Jack Kevorkian burst onto the scene.<sup>246</sup> His actions posed particular problems for the medical profession. On the one hand, he seemed an unusual individual with some rather bizarre ideas<sup>247</sup> who appeared to glory in the media attention each time he

at 848-49. They did note that the likelihood of prosecution for euthanasia is much higher than for physician-assisted suicide, thus leading to additional deterrence among physicians. See *id.* at 849.

242. Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients [Letter]*, 321 NEW ENG. J. MED. 975, 978 (1989). According to the authors, an ethical action is one that "would conform to professionally endorsed principles and standards." *Id.*

243. See *The Physician's Responsibility Toward Hopelessly Ill Patients [Letters]*, 321 NEW ENG. J. MED. 975-78 (1989).

244. James R. Boyce, *The Physician's Responsibility Toward Hopelessly Ill Patients [Letter]*, 321 NEW ENG. J. MED. 976 (1989).

245. See Orentlicher, *supra* note 2, at 1844-45. This article also provoked a good deal of discussion. See *Physician Participation in Assisted Suicide [Letters]*, 263 JAMA 1197-98 (1990).

246. See *supra* note 89 and accompanying text.

247. Kevorkian's now famous proposals include using death row inmates for medical experiments and organ donations, and transfusing blood directly from dead soldiers into the nearby wounded on the battlefield. See Belkin, *supra* note 89, at A1. More recently, he attempted to put together an exhibition of Hitler's paintings to raise money for charity. See *Kevorkian and Hitler Art*, N.Y. TIMES, May 19, 1994, at B7. Kevorkian later clarified that what he had attempted to organize was an exhibition of artwork by three World War II leaders—Winston Churchill, Dwight D. Eisenhower, and Adolf Hitler. See *Kevorkian Explains Idea for Hitler Art Show*, N.Y. TIMES, May 22, 1994, at 24.

used his "suicide machine" or carbon monoxide contraption.<sup>248</sup> On the other hand, he was a licensed member of the medical profession.<sup>249</sup> There seems little doubt that if Jack Kevorkian had not had an "M.D." after his name, physicians, and the general public for that matter, would have dismissed him out of hand as a dangerous extremist. But, Kevorkian was shrewd enough to capitalize on the respect and credibility that are accorded someone with a medical degree by repeatedly contextualizing his actions as those of a physician,<sup>250</sup> and by framing assisted suicide as a purely medical act.<sup>251</sup>

As Kevorkian attempted to place his actions solidly within the medical sphere, the medical profession responded by disowning him. This was a two-step process; the first step took place when physicians universally condemned his actions,<sup>252</sup> the second when Kevorkian was

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248. See *Kevorkian Details His Role in Suicide*, N.Y. TIMES, Aug. 7, 1993, at 28 (describing in detail Kevorkian's use of carbon monoxide to assist an individual to die). Kevorkian was forced to turn to carbon monoxide after Michigan state officials revoked his license to practice medicine, thus depriving him of access to the pharmaceutical agents needed to operate his suicide machine. See *Kevorkian, Pushing for Jail, Aids in Suicide in His Home*, N.Y. TIMES, Oct. 23, 1993, at 8.

249. Kevorkian is a retired pathologist who received his medical degree from the University of Michigan. See Belkin, *supra* note 89, at A1.

250. See, e.g., Geoffrey Nels Fieger, *Kevorkian's Crusade*, N.Y. TIMES, Dec. 3, 1993, at A33 (containing a statement by Kevorkian's lawyer that "'Jack is a physician first and foremost'"); *Kevorkian Takes Stand in Own Defense*, N.Y. TIMES, Apr. 28, 1994, at A16 (quoting Kevorkian, "[a]ny physician who is a real physician would care for nothing, nothing, nothing other than the welfare of his patient"); *id.* (quoting Kevorkian, "I didn't want Mr. Hyde to die, just as a surgeon doesn't want to cut off a leg"); Don Terry, *Kevorkian Assists in Death of His 17th Suicide Patient*, N.Y. TIMES, Aug. 5, 1993, at A14 (quoting Kevorkian, "I will always [help] when a patient needs me").

251. See, e.g., *Doctors Offer Some Support to Kevorkian*, N.Y. TIMES, Dec. 5, 1995, at A21 (quoting one doctor as saying, "This is a medical matter—solely"); *Kevorkian Details His Role in Suicide*, N.Y. TIMES, Aug. 7, 1993, at 28 (noting that Kevorkian has always insisted that assisted suicide is a medical rather than a legal issue); *Kevorkian Is Charged Again with Aiding a Suicide*, N.Y. TIMES, Nov. 30, 1993, at A18 (quoting Kevorkian, "[t]he only people qualified to regulate this are medical men. This is solely a medical matter . . ."); *Kevorkian's Ballot Drive on Suicide Aid Stumbles*, N.Y. TIMES, July 6, 1994, at A14 (quoting Kevorkian, "[t]his is a medical issue, but again religion is sticking its nose into a secular right"); Jack Lessenberry, *In Latest Suicide Trial, Kevorkian Asserts 'Duty as a Doctor'*, N.Y. TIMES, May 4, 1996, at 10 (quoting Kevorkian, "[m]y intent was to carry out my duty as a doctor and to end their suffering").

252. See Marcia Angell, *Don't Criticize Dr. Death . . .*, N.Y. TIMES, June 14, 1990, at A27 (noting that the criticism of Kevorkian "is nearly universal"); Altman, *supra* note 10, at C3 (stating that "[f]ew if any doctors have voiced support for Dr. Kevorkian's action"); Christine K. Cassel & Diane E. Meier, *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 NEW ENG. J. MED. 750, 750 (1990) (remarking that physicians, lawyers, and ethicists uniformly expressed their disapproval of Kevorkian's actions and his suicide machine).

In an interesting twist, a small group of Michigan physicians, calling themselves the "Physicians for Mercy," recently allied themselves with Jack Kevorkian in his battle for

literally disenfranchised from the profession of medicine.<sup>253</sup> This process of disowning Kevorkian created philosophical difficulties for those physicians who found his actions abhorrent but who supported the concepts of physician-assisted suicide and euthanasia. Their response was to distance themselves from Kevorkian, but to continue the argument that society must not lose sight of "the profound and genuine suffering and legitimate wish for release that motivates some patients to consider suicide."<sup>254</sup>

#### 4. Dr. Timothy Quill

If the medical profession distanced itself from Jack Kevorkian, it positively embraced Timothy Quill. Dr. Quill catapulted onto center stage on the issue of physician-assisted suicide when on March 7, 1991, *The New England Journal of Medicine* published Quill's narrative of his role in the death of one of his patients.<sup>255</sup> In condensed form, Quill told the following story:

Diane was feeling tired and had a rash. A common scenario, though there was something subliminally worrisome that prompted me to check her blood count. Her hematocrit was 22, and the white-cell count was 4.3 with some metamyelocytes and unusual white cells. . . . I called Diane and told her it might be more serious than I had initially

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physician-assisted death. See *Small Group of Doctors Supports Concept of Assisting in Suicides*, N.Y. TIMES, Oct. 31, 1995, at A20. They have since developed a set of guidelines which would require that a mentally competent patient seeking assisted death consult several physicians, including a psychiatrist, a specialist in the patient's disease, and a specialist in pain management. See *Doctors Offer Some Support to Kevorkian*, N.Y. TIMES, Dec. 5, 1995, at A21. If the consulting doctors agreed that physician-assisted suicide was appropriate under the circumstances, a qualified physician "obitriatrist" would then assist the individual to die. *Id.* The group endorses the term "patholysis," which signifies the relief of suffering, for this process rather than the term "assisted suicide." *Id.* Earlier this year, members of Physicians for Mercy joined Jack Kevorkian for the first time as he assisted the suicide of a Canadian citizen. See *Kevorkian Back at Trial as Talk of Detroit Is of Another Suicide*, N.Y. TIMES, May 10, 1996, at A16.

253. The Michigan Board of Medicine in 1991 suspended his license indefinitely, making it illegal for Kevorkian to practice medicine in the state of Michigan. See *Michigan Board Suspends License of Doctor Who Aided in Suicides*, N.Y. TIMES, Nov. 21, 1991, at D22. Likewise, after a request by the California Medical Board, an administrative law judge suspended Kevorkian's California medical license in 1993. See *Doctor Who Aided Suicide Loses License in California*, N.Y. TIMES, Apr. 28, 1993, at A13. As a result, Kevorkian is no longer licensed to practice medicine anywhere in the United States.

254. Cassel & Meier, *supra* note 252, at 751.

255. See Timothy E. Quill, *Death and Dignity: A Case of Individualized Decisionmaking*, 324 NEW ENG. J. MED. 691 (1991). Dr. Quill is Associate Professor of Medicine and Psychiatry at the University of Rochester School of Medicine and Dentistry in Rochester, New York, where he was a hospice medical director for eight years. He also has a primary care internal medicine practice at The Genesee Hospital in Rochester, New York.

thought . . . . When she pressed for the possibilities, I reluctantly opened the door to leukemia. . . .

Diane was no ordinary person (although no one I have ever come to know has been really ordinary). She was raised in an alcoholic family and had felt alone for much of her life. She had vaginal cancer as a young woman. Through much of her adult life, she had struggled with depression and her own alcoholism. I had come to know, respect, and admire her over the previous eight years as she confronted these problems and gradually overcame them. She was an incredibly clear, at times brutally honest, thinker and communicator. As she took control of her life, she developed a strong sense of independence and confidence. . . .

. . . .

The bone marrow confirmed the worst: acute myelomonocytic leukemia. In the face of this tragedy, we looked for signs of hope. This is an area of medicine in which technological intervention has been successful, with cures 25 percent of the time . . . . As I probed the costs of these cures, I heard about induction chemotherapy (three weeks in the hospital, prolonged neutropenia, probable infectious complications, and hair loss; 75 percent of patients respond, 25 percent do not). For the survivors, this is followed by consolidation chemotherapy . . . . Those still alive, to have a reasonable chance of long-term survival, then need bone marrow transplantation . . . . Though hematologists may argue over the exact percentages, they don't argue about the outcome of no treatment—certain death in days, weeks, or at most a few months.

Believing that delay was dangerous, our oncologist broke the news to Diane and began making plans . . . . [S]he was enraged at his presumption that she would want treatment, and devastated by the finality of the diagnosis. All she wanted to do was go home and be with her family. She had no further questions about treatment and in fact had decided that she wanted none. . . .

. . . She remained very clear about her wish not to undergo chemotherapy and to live whatever time she had left outside the hospital. As we explored her thinking further, it became clear that she was convinced she would die during the period of treatment and would suffer unspeakably in the process . . . .

. . . .

Just as I was adjusting to her decision, she opened up another area that would stretch me profoundly. It was extraordinarily important to Diane to maintain control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die. . . . In our discussion, it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting

the most out of the time she had left until she found a safe way to ensure her death. . . . I told Diane that information was available from the Hemlock Society that might be helpful to her.

A week later she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. . . . It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional, and personal. . . .

The next several months were very intense and important for Diane. . . . After three tumultuous months, there were two weeks of relative calm and well-being, and fantasies of a miracle began to surface.

Unfortunately, we had no miracle. Bone pain, weakness, fatigue, and fevers began to dominate her life. . . . [I]t was clear that the end was approaching. Diane's immediate future held what she feared the most—increasing discomfort, dependence, and hard choices between pain and sedation. . . . When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. . . .

Two days later her husband called to say that Diane had died.<sup>256</sup>

Following publication of Diane's story, Quill became an overnight celebrity. New York law enforcement officials initially declined to prosecute him until an anonymous tip identified the deceased as Patricia Diane Trumbull.<sup>257</sup> When an autopsy revealed the presence of a lethal dose of barbiturates, a grand jury was impaneled to consider whether to indict Dr. Quill on criminal charges of intentionally assisting in a suicide.<sup>258</sup> The grand jury, after hearing Quill testify,<sup>259</sup> recommended against prosecution.<sup>260</sup>

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256. Quill, *supra* note 255, at 691-93.

257. See William Glaberson, *Panel to Decide: Should Doctor Who Aided Suicide Be Tried?*, N.Y. TIMES, July 22, 1991, at B1.

258. See *id.*

259. Quill waived his Fifth Amendment right and testified at the grand jury proceeding. See Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 705 (1994).

260. See Lawrence K. Altman, *Jury Declines to Indict a Doctor Who Said He Aided in a Suicide*, N.Y. TIMES, July 27, 1991, at 1. The New York State Board of Professional Conduct also declined to discipline Quill for his actions. See Quill, *supra* note 259, at 706;

Dr. Quill went public with his role in Diane's death in part to present an alternative to the actions of Jack Kevorkian and his suicide machine.<sup>261</sup> The hallmarks of this setting—a clearly competent patient with a certain diagnosis of a terminal illness, a longterm physician-patient relationship, the deliberate and painstaking exploration of the issue by patient and physician, and the family's involvement in the decision—all served to differentiate this case from the Kevorkian-assisted deaths, as well as the "It's Over, Debbie" scenario. Before long, Dr. Quill was being hailed as having provided the paradigm for responsible physician-assisted suicide.

### B. *The Debate from Within*

The anonymous gynecology resident, the Council of Twelve, Jack Kevorkian, and Timothy Quill—these individuals have had a profound effect on the discourse on assisted death. Their accounts, recorded in the pages of the medical literature, have provoked wave after wave of commentary from within the medical community.<sup>262</sup> These responsive arguments can usefully be divided into two categories: those that address the broad substantive question of whether to support assisted suicide and euthanasia, and those that deal specifically with the proper role of the physician, if any, in assisted death.

#### 1. Medical Perspectives on Assisted Death

The reasons for and against assisted death articulated in the medical literature tend to mirror the broader debate within society.<sup>263</sup> Those in favor of assisted death base their support first on notions of personal autonomy, contending that the right to request and receive

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Lisa W. Foderaro, *New York Will Not Discipline Doctor for His Role in Suicide*, N.Y. TIMES, Aug. 17, 1991, at 25.

261. See QUILL, *supra* note 8, at 123-25; Glaberson, *supra* note 257, at B1; see also Jack P. Freer, *Death and Dignity: The Case of Diane [Letter]*, 325 NEW ENG. J. MED. 658, 658 (1991) (stating that Dr. Quill provided a useful counterpoint to the Kevorkian and "It's Over, Debbie" cases); Lawrence K. Altman, *Doctor Says He Gave Patient Drug to Help Her Commit Suicide*, N.Y. TIMES, Mar. 7, 1991, at A1 (quoting Professor George Annas as saying, "[t]he difference in the cases is like night and day because Dr. Quill's patient received good care and she was long known to him").

262. One advantage of the medical literature over traditional legal literature such as law reviews is that medical journals frequently contain "Letters to the Editor" sections where individuals can critique and comment on recently published articles.

263. Because the general arguments for and against physician-assisted suicide and euthanasia have been dealt with extensively elsewhere, see *supra* note 8, my goal here is to summarize those positions rather than examine them in great detail.

assistance in ending one's own life is an essential element of personal liberty and the right to self-determination.<sup>264</sup> Implicit in this argument is the view that there is no difference between the right to choose death by refusal of life-sustaining treatment, already recognized as a moral and legal right in this country, and the right to choose death through more active means.<sup>265</sup> Second, proponents ground their support in notions of mercy, arguing that it is inhumane to force an individual to continue a life of unbearable suffering and pain.<sup>266</sup> Proponents point out that physician-assisted suicide occurs despite the prohibitions against it;<sup>267</sup> a more open and regulated process would produce a higher level of accountability and limit its use to clearly appropriate cases.<sup>268</sup> They maintain that unless we give people facing intolerable suffering some measure of control over the dying process, we will continue to see the kinds of abuses exemplified by "It's Over, Debbie" and the Kevorkian cases.<sup>269</sup>

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264. See Robert I. Misbin, *Physicians' Aid in Dying*, 325 NEW ENG. J. MED. 1307, 1308 (1991); Singer & Siegler, *supra* note 1, at 1881.

265. See Marcia Angell, *Euthanasia*, 319 NEW ENG. J. MED. 1348, 1349-50 (1988); Edmund D. Pellegrino, *Ethics*, 265 JAMA 3118, 3118-19 (1991); Preston, *supra* note 226, at 37. Proponents of assisted death take the position that it is unjust to allow those who are "fortunate" enough to be dependent on life-sustaining treatment to choose death by refusal of treatment but to deny that same choice to those not dependent on some form of life support. See Angell, *supra*, at 1350; Pellegrino, *supra*, at 3118-19.

266. See Angell, *supra* note 265, at 1349.

267. See Kenneth V. Iverson, *Death and Dignity: The Case of Diane [Letter]*, 325 NEW ENG. J. MED. 659, 659 (1991) ("In discussing bioethics with groups of physicians, I have rarely found a primary care clinician who has not helped a patient to die . . ."); Wanzer et al., *supra* note 1, at 848 (asserting that physician-assisted suicide is not a rare occurrence).

268. See Cassel & Meier, *supra* note 252, at 751. Physicians who support legalization of physician-assisted death also generally support safeguards that would limit such assistance to competent, terminally ill adults for whom comfort care and pain relief have not succeeded in making life tolerable. See, e.g., Angell, *supra* note 265, at 1350; Guy I. Benrubi, *Euthanasia—The Need For Procedural Safeguards*, 326 NEW ENG. J. MED. 197, 197-98 (1992); Franklin G. Miller et al., *Regulating Physician-Assisted Death*, 331 NEW ENG. J. MED. 119, 119 (1994). Timothy Quill rejects the notion that physician-assisted suicide should be available only to the terminally ill. He would support its use in cases where the individual is not terminally ill but suffers from an incurable, progressive disease. See Timothy E. Quill et al., *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 NEW ENG. J. MED. 1380, 1381-82 (1992).

269. See Cassel & Meier, *supra* note 252, at 750-51. Some have suggested that Janet Adkins might not have taken her life so early in the course of her disease if she could have been assured that she would receive assistance later as her condition deteriorated. See Misbin, *supra* note 264, at 1308.



In contrast, the opposition charges that assisted death represents an assault on the sanctity of life,<sup>270</sup> and they explicitly reject the contention that withdrawal of life-sustaining treatment and assisted death are medically and ethically indistinguishable.<sup>271</sup> They warn that assisted suicide and euthanasia threaten to send us down a slippery slope in which human life is increasingly devalued.<sup>272</sup> Further, opponents of assisted death raise the concern that this devaluation will be selective, operating against the weak and powerless in society to produce involuntary euthanasia,<sup>273</sup> and that safeguards will not adequately protect against this kind of abuse.<sup>274</sup> They thus take the position that the interests of the individual who is suffering and wants to die must bow to a concern for other vulnerable members of society, who might be euthanized without their consent or coerced into consenting if the proscription against assisted death were relaxed.<sup>275</sup> Put simply, "the public good served by the prohibition of euthanasia outweighs the private interests of the persons requesting it."<sup>276</sup>

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270. Proponents of euthanasia disagree, arguing that by effectuating self-determination, assisted death enhances rather than diminishes respect for life. See Angell, *supra* note 265, at 1350.

271. See Pellegrino, *supra* note 2, at 96. Pellegrino distinguishes the two on the basis that with withdrawal of treatment, the underlying disease kills the patient, whereas with assisted death, the physician both intends and brings about the patient's death. See *id.*

272. See Angell, *supra* note 265, at 1348. For those individuals whose religious beliefs dictate that life is a gift and that human beings are stewards rather than masters of their bodies, assisted death is not just a slippery slope—it is a moral wrong in and of itself. See Pellegrino, *supra* note 265, at 3119.

273. See Angell, *supra* note 265, at 1349; Singer & Siegler, *supra* note 1, at 1882. Drs. Singer and Siegler suggest four ways in which acceptance of voluntary euthanasia might lead to involuntary euthanasia. First, individuals might be secretly euthanized without their consent as allegedly happens in the Netherlands. Second, chronically ill or dying patients could be pressured into consenting in order to relieve their families of financial or emotional strain. Third, euthanasia would likely be extended to incompetent individuals through the use of substituted judgment or benefits-and-burdens analysis. And fourth, the poor, the elderly, the disabled and physically handicapped, and other vulnerable members of society might be subtly coerced into consenting. See *id.* at 1882.

274. Edmund D. Pellegrino, *Compassion Needs Reason Too*, 270 JAMA 874, 874 (1993) ("[Assisted suicide and euthanasia] are not containable by placing legal limits on their practice. Arguments to the contrary, the 'slippery slope' is an inescapable logical, psychological, historical, and empirical reality."); Singer & Siegler, *supra* note 1, at 1882-83.

275. See Singer & Siegler, *supra* note 1, at 1882 (using the Netherlands as an example of this phenomenon).

276. *Id.*; see also Angell, *supra* note 265, at 1349.

## 2. Medical Perspectives on the Physician's Role

Physicians and the organized medical profession have no particular expertise on the general question of whether we as a society should support or oppose assisted death. It is not surprising then that the discourse within the medical community reflects the larger societal debate. The real value of the dialogue between physicians becomes apparent when one broaches the question of physician participation in assisted death, because here physicians *do* have special expertise, as well as immense personal and professional investments in the resolution.

Members of the medical community appear to agree that the primary goals of medicine are to preserve and sustain life and to relieve pain and suffering.<sup>277</sup> There is, however, a great deal less agreement on the proper role of the physician when these two goals come into conflict, as they arguably do when a terminally ill individual is suffering and asks the physician to help him or her die. The medical literature reveals a critical division among physicians on the question whether giving assistance under these circumstances lies along the medical continuum of providing compassionate care to dying patients or whether, in fact, such assistance is antithetical to the physician's role as healer. The question thus becomes whether the physician's role, properly conceived, is broad enough to encompass assisted suicide and euthanasia. The answers provided by physicians to this question are remarkable in that they are almost mutually exclusive. This fundamental difference in perspective is well-illustrated by a recent exchange between two physicians. A representative of the American Medical Association asserted that "[w]hat the sick need and are entitled to seek from the efforts of physicians is *health*."<sup>278</sup> A colleague responded, "[s]ubstitute the word *help* for *health* and the phrase becomes universally apt."<sup>279</sup>

On what foundation do the participants in this debate rest their respective positions? A member of the medical community who opposes physician involvement in assisted death would likely justify that opposition as follows: Physicians throughout the ages have been

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277. See Orentlicher, *supra* note 2, at 1844 (stating that "a physician provides medical care for two reasons: to sustain life and to relieve suffering").

278. *Id.* at 1845 (emphasis added). He reasoned that treatment designed to produce death does not heal and is therefore inconsistent with the physician's proper role. See *id.*

279. Frederick R. Abrams, *Physician Participation in Assisted Suicide [Letter]*, 263 JAMA 1197, 1197 (1990).

healers first and foremost, in the same way that medicine has traditionally been a healing art.<sup>280</sup> Because physician-assisted death, by definition, is not undertaken to heal the patient and in fact directly contravenes the primary goals of medicine,<sup>281</sup> physician participation threatens the moral integrity of the profession.<sup>282</sup> If the medical community insists on endorsing such practices, the profession will inevitably lose the trust and respect that society accords physicians on the basis of their role as healers and protectors of life.<sup>283</sup> Thus, as the power to heal is expanded to include the power to "kill," patients will come to fear their doctors.<sup>284</sup>

According to the opponents, because physician-assisted suicide and euthanasia are inconsistent with the goals of medicine, the medical profession is under no moral, ethical, or legal obligation to grant a patient's request for assisted death.<sup>285</sup> When the refusal to condone such practices is grounded on valid professional and societal concerns, such refusal does not indicate a lack of compassion on the part of doctors.<sup>286</sup> Conversely, the fact that physician-assisted death is a common practice among physicians, or the fact that their participation is motivated by compassion, neither changes the nature of the underlying act nor provides a convincing justification for its commission.<sup>287</sup>

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280. Edmund Pellegrino describes medicine as a "healing relationship" in which the physician restores the patient to health or assists the patient in coping with disability and death where a cure is not possible. See Pellegrino, *supra* note 2, at 98.

281. See Orentlicher, *supra* note 2, at 1844.

282. See Singer & Siegler, *supra* note 1, at 1883; Pellegrino, *supra* note 2, at 98.

283. See Ronald Anderson et al., *The Physician's Responsibility Toward Hopelessly Ill Patients* [Letter], 321 JAMA 975, 975 (1989) (stating that patients would no longer trust or disclose their true feelings to physicians who actively terminate life); Gaylin et al., *supra* note 230, at 2140; Sanford A. Marcus, *The Physician's Responsibility Toward Hopelessly Ill Patients* [Letter], 321 JAMA 978, 978 (1989) (arguing that society holds physicians in esteem solely on the basis of their role as healers); Orentlicher, *supra* note 2, at 1845 (contending that assisted suicide would undermine the essential element of trust in the patient-physician relationship); Pellegrino, *supra* note 2, at 98 (stating that the trust relationship would be distorted if the healing function were expanded to include killing).

284. See Pellegrino, *supra* note 2, at 98. Pellegrino argues that a patient will never know whether a physician's motivation for promoting euthanasia is because it is the best option for the patient or because the physician devalues the patient's life and wants to conserve scarce medical resources. See *id.*

285. See Frank J. Brescia et al., *The Physician's Responsibility Toward Hopelessly Ill Patients* [Letter], 321 NEW ENG. J. MED. 977, 977 (1989); Orentlicher, *supra* note 2, at 1845.

286. See Myles N. Sheehan, *Assisted Suicide and Euthanasia* [Letter], 324 NEW ENG. J. MED. 1436, 1436 (1991).

287. See Pellegrino, *supra* note 2, at 97-99.

No one in the profession would deny the duty of the physician to help the patient achieve a "good death."<sup>288</sup> But, opponents of assisted death contend most individuals can experience a dignified dying process with a minimum of pain and suffering without resort to physician-assisted death.<sup>289</sup> What these individuals need, according to this view, is compassionate care with attention to pain relief and emotional support—all things within the capabilities of physicians to provide. Individuals in this country seek assisted death precisely because medical professionals have failed to provide effective supportive and palliative care to the dying.<sup>290</sup> The solution to this admittedly serious problem is not to promote assisted death, but rather to demand that physicians improve pain control, provide adequate comfort care, and make more appropriate use of life-sustaining treatments.<sup>291</sup> To countenance physician-assisted suicide now would be nothing short of disastrous because it would eliminate the pressure presently directed at the profession to improve its care of the dying.<sup>292</sup>

In contrast, a member of the medical community who supports physician participation in assisted death might justify that position in the following manner: For persons who are dying, "relieving symptoms, enhancing control, and preserving dignity" ought to be the primary goals of medicine.<sup>293</sup> The concept of the physician as "healer" under these circumstances clearly encompasses the obligation to relieve a patient's suffering.<sup>294</sup> But in some rare instances, despite adequate hospice and comfort-care management, individuals experience intolerable pain and suffering that no amount of emotional and pharmacological support can alleviate.<sup>295</sup> Or, in another scenario, the individual may be faced with a choice between unbearable pain

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288. See *id.* at 97.

289. Proponents of this position claim that most pain can be adequately controlled with analgesic agents. See Singer & Siegler, *supra* note 1, at 1881.

290. See Joanne Lynn, *Euthanasia [Letter]*, 321 NEW ENG. J. MED. 119, 119 (1989).

291. See *id.*; Singer & Siegler, *supra* note 1, at 1883.

292. See *id.*

293. Timothy E. Quill, *Death and Dignity: The Case of Diane [Letter]*, 325 NEW ENG. J. MED. 660, 660 (1991).

294. See Preston, *supra* note 226, at 39.

295. See Quill, *supra* note 191, at 9. One physician described symptoms such as shortness of breath, nausea, and feelings of helplessness in dying patients that analgesic agents (pain relievers) did nothing to allay. See Richard Finley, *Euthanasia Debate [Letter]*, 323 NEW ENG. J. MED. 1771, 1771 (1990). Others suggested that even the best terminal care may not eliminate the loss of dignity that can accompany terminal illness. See Aaron Spital & Max Spital, *Euthanasia Debate [Letter]*, 323 NEW ENG. J. MED. 1771, 1771 (1990).

and unacceptable levels of sedation caused by the pain medications.<sup>296</sup> The physician who refuses to assist such a person to achieve a dignified death through physician-assisted suicide or euthanasia abandons the patient at his or her time of greatest need. Not only does the physician abandon the patient, but she frequently does so under circumstances where the physician is directly responsible, through the use of medical technology that prolongs life, for bringing the patient to this state of unbearable pain and suffering.<sup>297</sup>

When the goals of sustaining life and relieving suffering conflict, it is for the patient to decide which goal medicine ought to serve, according to proponents.<sup>298</sup> Physicians need to be sensitive to the meaning their patients ascribe to their lives and be prepared to assist when dying a dignified and controlled death comes to mean more to their patients than prolonging life.<sup>299</sup> That physicians routinely ignore their dying patients' wishes is symptomatic of physicians' seeming inability to assist them through the dying process, either because the physicians have not received proper training in the care of the dying, or because they are unwilling to confront their own mortality, or both.<sup>300</sup> Whatever the cause, physicians risk a greater loss of trust if they continue to hold patients hostage to technology than if they participate in helping them to die.<sup>301</sup> Thus, unless the power to heal is expanded to include the power to help, patients will come to fear not death, but physicians.<sup>302</sup>

Despite the very different perceptions of those members of the medical profession who support physician-assisted death and those who oppose it, these two groups do share some common ground. They agree that physicians' obligations to their dying patients are substantial and include the professional and ethical duties to stay with their patients through the dying process. They further agree that physicians must do everything medically possible to minimize the

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296. See Quill, *supra* note 255, at 693 (describing Diane's difficult choice between pain and sedation).

297. See Benrubi, *supra* note 268, at 197-98 (asserting that through the use of technological interventions such as chemotherapy and radiation therapy, physicians extend patients' lives but also prolong their suffering).

298. See Abrams, *supra* note 279, at 1197. Or, as Preston puts it, "The conflict between the obligation to heal and the obligation to relieve suffering becomes one between professional values and patients' values." Preston, *supra* note 226, at 39.

299. See Cassel & Meier, *supra* note 252, at 751.

300. See *id.*; Christine K. Cassel & Diane Meier, *Assisted Suicide and Euthanasia [Letter]*, 324 NEW ENG. J. MED. 1436, 1436-37 (1991).

301. See Preston, *supra* note 226, at 39.

302. See *id.*

distress and discomfort of the terminally ill through the use of pain management, palliative care, and emotional support.<sup>303</sup> And virtually everyone involved concedes that the medical profession does not adequately fulfill its obligations toward the dying, and in fact fails miserably in some cases.<sup>304</sup> But, they differ strongly on the question of how far a physician can and should go to discharge his or her duties to a dying patient.

### 3. Physician Survey Results

A survey conducted among 1355 randomly selected physicians in the state of Washington illustrates this polarization on the issue of physician-assisted death.<sup>305</sup> The study was designed to elicit information on whether physicians believe that assisted suicide and euthanasia are ethical, whether either or both should be legalized, and whether physicians would be willing to participate in these practices.<sup>306</sup>

The results of the survey are fascinating. Thirty-nine percent of physicians agreed that physician-assisted suicide<sup>307</sup> is never ethically justified, while fifty percent disagreed with that statement.<sup>308</sup>

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303. See Quill, *supra* note 191, at 9; Pellegrino, *supra* note 274, at 874; Wanzer et al., *supra* note 1, at 847 (stating that "[t]o allow a patient to experience unbearable pain or suffering is unethical medical practice").

304. See Singer & Siegler, *supra* note 1, at 1881-82. Physicians who underuse pain relievers in the care of the dying may do so because of concerns about depressing respiration or causing drug addiction. See *id.* at 1882.

305. See Jonathan S. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 NEW ENG. J. MED. 89 (1994).

306. See *id.* at 89. The survey authors selected potential respondents from a Washington State Medical Association data base that included both members and nonmembers of the Association. See *id.* Two hundred fifty physicians were randomly selected from each of the specialties of general internal medicine, family practice, general surgery, psychiatry, and a combination of other specialties. See *id.* In addition, 166 hematologists and oncologists were added to the survey sample. See *id.* Of these 1416 physicians, 1355 were found to be eligible for the study and of these, 938 responded, for a response rate of 69%. See *id.* at 90. The survey consisted of 48 questions about the characteristics of the respondents, attitudes about assisted suicide and euthanasia, views about legalization, willingness to participate in assisted suicide or euthanasia, and views about safeguards or restrictions. See *id.* Responses were recorded using a five-point scale, ranging from "strongly agree" to "strongly disagree." *Id.* For reporting purposes, the five response categories were collapsed into three: strongly agree or agree, neutral, and disagree or strongly disagree. See *id.*

307. To avoid confusion, the authors of the study substituted the phrase "prescription of medication [e.g., narcotics or barbiturates] or the counseling of an ill patient so he or she may use an overdose to end his or her own life" for the term "physician-assisted suicide." *Id.*

308. See *id.*

Euthanasia<sup>309</sup> received a somewhat lower approval rating, with forty-eight percent agreeing that euthanasia is never ethically justified.<sup>310</sup> On the question of legalization, just over fifty percent thought physician-assisted suicide and euthanasia should be legal under some circumstances,<sup>311</sup> but not all of those in favor of legalizing physician-assisted suicide and euthanasia would be willing to participate themselves. Forty percent of respondents stated they would be willing to assist a patient commit suicide, while thirty-three percent would be willing to perform euthanasia.<sup>312</sup> The majority who favored legalization of physician-assisted suicide and euthanasia also expressed strong support for safeguards such as requiring an independent witness to the patient's request, an established relationship between physician and patient, two physicians who agree on the proposed course, a waiting period between the request and the assistance, and the exhaustion of available alternatives such as pain control and hospice care before resort is made to assisted death.<sup>313</sup>

Respondents' attitudes about assisted death varied considerably across specialties. Hematologists and oncologists, who as a group had the most exposure to dying patients, were the most strongly opposed to physician-assisted suicide and euthanasia.<sup>314</sup> In contrast, psychiatrists, who as a group had the least exposure to dying patients, were the most strongly in favor of the two practices.<sup>315</sup> The study also revealed that men were more likely than women to believe that assisted suicide is unethical.<sup>316</sup>

The reasoning behind these positions closely tracks the arguments set forth in the medical literature. A majority of those who opposed assisted death considered it inconsistent with the physician's proper role; a majority of supporters thought it entirely consistent with

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309. To avoid confusion, the authors substituted the phrase "deliberate administration of an overdose of medication to an ill patient at his or her request with the primary intent to end his or her life" for the term "euthanasia." *Id.*

310. *See id.* Forty-two percent of respondents disagreed with the statement that euthanasia is never ethically justified. *See id.*

311. The numbers were 53% in favor of legalizing assisted suicide and 54% in favor of legalizing euthanasia. *See id.* at 90-91.

312. *See id.*

313. *See id.* at 92-93.

314. *See id.* at 93. The study's authors posited that hematologists and oncologists as a group might believe that more effective use of treatments for pain and suffering would eliminate the need for assisted death. *See id.*

315. *See id.*

316. *See id.* at 91. The significance of this finding is unclear since the study did not reveal a gender difference on the ethics of euthanasia. *See id.*

their role as physicians.<sup>317</sup> Opponents expressed concerns over the potential for abuse; proponents felt strongly that physicians should respect patients' rights to self-determination.<sup>318</sup> Opponents viewed currently available treatments as adequate to eliminate pain and suffering; proponents disagreed.<sup>319</sup>

A recent survey of Michigan physicians yielded similar results. Fifty-six percent of Michigan physicians expressed approval for a plan to legalize physician-assisted death,<sup>320</sup> while thirty-five percent would be willing to assist their patients to die.<sup>321</sup> Interestingly, when presented with an additional option of "no law,"<sup>322</sup> a significant percentage of physicians who had expressed support for a ban on physician-assisted death shifted their support to the "no law" option,<sup>323</sup> suggesting that they would prefer that the legal system stay out of the area altogether.

Another survey, of Oregon physicians, revealed a somewhat higher level of physician approval and willingness to participate in assisted suicide.<sup>324</sup> Sixty-six percent responded that physician-assisted suicide would be ethical in some circumstances, and sixty percent felt that it should be legal in some cases.<sup>325</sup> Further, forty-six percent of

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317. See *id.* at 91-92.

318. See *id.* at 92.

319. See *id.*

320. See Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 NEW ENG. J. MED. 303, 306 (1996). These authors confined their survey to physicians who practiced specialties that involve caring for patients with terminal or chronic illnesses. See *id.* at 304. The response rate among eligible physicians was 74%. See *id.* at 306.

Similar to the Washington findings, physicians who had the least contact with terminally ill patients were the most likely to support legalized assisted suicide. See *id.* at 308. Further, physicians' religious beliefs correlated strongly with their positions—those who said religion was very important in their lives were the least likely to support physician-assisted death. See *id.*

321. See *id.* at 308. Contained within this 35% figure were 13% who would participate only in assisted suicide and 22% who would participate in assisted suicide and euthanasia. See *id.* at 306.

322. The "no law" options would either leave decisions about physician-assisted death to the doctor-patient relationship or subject those decisions to guidelines or regulations generated by the medical profession. See *id.* at 305 fig. 1.

323. See *id.* at 305 fig. 1 & 307.

324. See Melinda A. Lee et al., *Legalizing Assisted Suicide—Views of Physicians in Oregon*, 334 NEW ENG. J. MED. 310 (1996). This study surveyed physicians in the specialties of internal medicine, family practice, general practice, neurology, gynecology, therapeutic radiology, and surgery. See *id.* The response rate was 70% among eligible physicians. See *id.* at 311.

325. See *id.* at 311 & 312 fig. 1. Because The Oregon Death with Dignity Act would legalize only physician-assisted suicide and not euthanasia, the study's authors confined



the physicians surveyed expressed a willingness to prescribe a lethal dose of medication under appropriate circumstances if it were legal to do so.<sup>326</sup>

A subsequent survey of Washington physicians focused attention on the extent to which they received requests from patients for physician-assisted suicide or euthanasia and their responses to those requests.<sup>327</sup> The responses revealed that twenty-six percent of the physicians had received requests from their patients for physician-assisted suicide or euthanasia.<sup>328</sup> Physicians were then asked to provide case information about the last two individuals who had made such requests, including the physicians' responses.<sup>329</sup> Respondents provided information about 207 individuals who had requested physician-assisted death, and reported that they had provided a prescription for a lethal dose of medication to twenty-four percent of the patients who asked for physician-assisted suicide, and administered a lethal injection to twenty-four percent of the individuals who requested euthanasia.<sup>330</sup> In contrast, in the Oregon survey, twenty-one percent of respondents reported having previously received requests

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their questions to Oregon physicians' beliefs about and participation in physician-assisted suicide. *See id.* at 314.

Similar to the Michigan findings, physicians' unwillingness to participate in physician-assisted suicide was correlated with a Catholic or other Christian affiliation. *See id.* at 312. But unlike the Michigan and Washington surveys, this one found no correlation between specialty or rate of caring for the terminally ill and willingness to participate. *See id.*

326. *See id.* at 312 & fig. 2. Despite the fact that almost half of the physicians would consider writing such a prescription, many expressed practical concerns about which drugs to prescribe, whether they could recognize depression in their patients requesting assistance, and whether they could accurately predict that those patients had less than six months to live. *See id.* at 312-13.

327. *See* Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919 (1996). The survey authors randomly selected 25% of the state's family practice physicians and 25% of the internal medicine physicians as well as all physicians in subspecialties such as medical oncology, radiation oncology, cardiology, pulmonary medicine, rehabilitation medicine, and geriatrics to receive the questionnaires. The response rate was 57%. *See id.* at 920.

328. *See id.* As a group, oncologists were more likely to receive requests for physician-assisted death than other specialists, and those physicians who cared for greater numbers of terminally ill individuals received more requests. *See id.* at 920-21.

329. *See id.* at 920.

330. *See id.* at 921-23. The authors of the study conclude from these case reports that in Washington, 24% of patient requests for physician-assisted suicide or euthanasia are granted. *See id.* at 924. It is not clear that this conclusion is valid. The physicians were asked to provide information about the last two patients who requested assisted death from them, which may or may not have been representative of the physicians' total experience with physician-assisted death. In order to draw the above conclusion, the researchers should have asked physicians to report both the total number of requests they had received while in practice and the number of those requests that they granted.

for assisted suicide, but only seven percent reported having complied with those requests.<sup>331</sup>

What conclusions can be drawn from these physician surveys in Washington, Michigan, and Oregon? First, while there is no clear consensus among the medical profession, the level of physician support for legalized assisted death is quite high (although not as high as the general public's).<sup>332</sup> Second, a lower percentage of physicians are willing to participate than actually support its legalization. And third, despite the illegality, or at least legal uncertainty, surrounding physician-assisted death, some physicians are providing assisted death services to their terminally ill and suffering patients in numbers that are not insignificant. As the authors of one of the surveys noted, the varying, and perhaps shifting, attitudes of physicians on the issue of assisted death have important implications for legislative and policy developments.<sup>333</sup> In the end, these authors offered what all commentators in this area seem to offer: a call for continued discourse on the role of physician-assisted suicide and euthanasia in the care of the dying.<sup>334</sup>

#### IV. THE PHYSICIAN'S ROLE: A SOCIETAL PERSPECTIVE

This debate within the medical community will not be resolved in the near future, particularly since the concept of physician-assisted death strikes at the very core of what it means to be a physician. However, the profession's lack of consensus on whether to support and take part in assisted suicide and euthanasia should not deter those outside medicine from exploring the question. While physicians bring considerable expertise to the discussion of the physician's proper role, other citizens need not feel bound by any one resolution the medical community comes to, nor should they feel constrained by the various justifications physicians offer for their positions. It is possible that there are additional reasons, not yet fully articulated, why society ought to think again before it places assisted death within the province of medicine. These more subtle arguments have perhaps escaped comment because those most competent to make the arguments, physicians themselves, have the least interest in doing so.

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331. See Lee et al., *supra* note 324, at 313.

332. See *supra* Part II.A; see also Bachman et al., *supra* note 320, at 306 (describing a survey revealing that 66% of the Michigan public supported one of two plans to legalize physician-assisted death as compared to 56% of Michigan physicians).

333. See Cohen et al., *supra* note 305, at 94.

334. See *id.* at 94.

### A. *Asking the Process Question*

I propose to raise these arguments by challenging the assumption that we have no choice but to look to the medical profession to facilitate and regulate assisted death. For purposes of this analysis, I will posit that either we have reached a societal consensus in support of assisted death or that the Supreme Court has ruled that states may not ban assisted suicide for the competent, terminally ill. The next question to be asked, and one that is invariably overlooked, is *who* is to do the assisting. This is a fundamental process question that should be answered before we take up the usual process questions concerning limits and safeguards to prevent abuses. Yet the issue of who is to assist does not come up in the standard debate.<sup>335</sup> The process question has been preempted by a legal system that allows those individuals or organizations seeking change to set the parameters for the discussion. Thus, citizens voting on Initiative 119, Proposition 161, or Ballot Measure 16 were not given a choice between assisted death performed by physicians and assisted death performed by someone else.<sup>336</sup> They had to choose physician-assisted suicide and euthanasia or nothing. Likewise, Judge Rothstein was not asked to strike down Washington's ban on assisted suicide generally. Instead, proponents challenged the statute only to the extent that it criminalizes physician-assisted suicide through the use of prescription drugs.<sup>337</sup> No wonder then that Judge Rothstein's opinion makes mention only of *physician* assistance to the terminally ill.<sup>338</sup> Similarly, the authors of a model act to authorize and regulate assisted suicide, which is intended for adoption by state legislatures, begin with the assumption that

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335. Or, if it does come up, it is dismissed out-of-hand. See, e.g., Angell, *supra* note 265, at 1350 (labeling as an "unsavory prospect" the creation of a profession dedicated to performing euthanasia).

336. See *supra* Part II.B.

337. See *supra* text accompanying note 105.

338. See, e.g., Compassion in Dying v. Washington, 850 F. Supp. 1454, 1460 (W.D. Wash. 1994) (defining the underlying constitutional issue as whether the state can deny a terminally ill person the option to commit physician-assisted suicide), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *cert. granted sub nom.* Washington v. Glucksberg, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110); see also *id.* at 1461 (discussing the issue of whether withdrawal of life-sustaining treatment is constitutionally distinct from death through drugs prescribed by a physician); *id.* at 1465 (stating that the court has no doubt that legislatures can devise regulations to define the proper boundaries of physician-assisted suicide); *id.* (holding that the challenged statute places a substantial obstacle in the path of a person seeking physician-assisted suicide).

physicians will provide the service and question only what type of physician should be allowed to assist.<sup>339</sup>

One way around this type of preemption is to conduct a thought experiment in which assisted suicide and euthanasia exist but in a form not usually presented for public consumption. Imagine a scenario in which euthanasia and assisted suicide are legal, but the power to assist or act is given to someone other than physicians. Please note that in conducting this thought experiment, I am not proposing sterile euthanasia clinics in which individuals arrive, sign consent forms, and are euthanized within the space of a few minutes.<sup>340</sup> Neither am I suggesting that family members or friends ought to bear the burden of helping a loved one to die. Rather, I am trying to construct a responsible picture of a society in which euthanasia and assisted suicide are regulated and controlled, but by a group other than the medical profession. For my purposes, we can even imagine a system that contains many of the safeguards that have been proposed in relation to physician-assisted death, such as competent adults, independent witnesses to the requests, waiting periods, family notification, and required reporting. The primary difference is that assistance would be provided by individuals that I will term "aides-in-dying."<sup>341</sup>

Because I have deliberately chosen to imagine a system with aides-in-dying rather than propose one, I feel no particular need to prove that such a system would constitute a *politically* feasible alternative to physician-assisted death. Nonetheless, I have little doubt that a regulated process using aides-in-dying, if done correctly, could function as a practical matter and survive constitutional challenge. Physicians might object to the notion that anyone else could be qualified to use pharmacological methods in assisting death. For example, one of the physician plaintiffs in the *Compassion in Dying* case, Dr. Geyman, stated to the court: "Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex

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339. See Charles H. Baron et al., *Statute: A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 HARV. J. ON LEGIS. 1, 17 (1996).

340. The specter of impersonal, profit-driven euthanasia clinics run by self-serving physicians has been raised in the debate over euthanasia and physician-assisted suicide. See Misbin, *supra* note 264, at 1310.

341. I have derived this label from the term "aid-in-dying," the euphemism for assisted death contained in Washington's Initiative 119. See *supra* note 31 and accompanying text. My intent here is to choose a term that does not carry pejorative connotations.

medical task.”<sup>342</sup> While Dr. Geyman is no doubt correct in asserting that an individual’s medical condition and drug regimen are relevant to this process, the notion that it takes four years of medical school, three or four years of residency training, and several years of practice to learn how to bring about a painless, dignified death with prescription medications is questionable. The real complexity in medicine lies in improving individuals’ conditions and keeping them alive through the use of medications, not in causing their deaths. Aides-in-dying could be adequately trained in the pharmacological aspects of assisted death and better trained than physicians in the psychological aspects.<sup>343</sup> As to the constitutional question, even if the Supreme Court were to hold that terminally ill individuals have a constitutional right to assisted death, the states would still have the power to regulate the process, including the power to license and regulate a group of individuals who were specially trained to provide competent assisted death services.<sup>344</sup>

That said, the notion of replacing physicians with trained aides-in-dying in this process is still a radical one. Even Edmund Pellegrino, a vehement critic of assisted death, asserts that physician participation is crucial to any effective social policy on this topic.<sup>345</sup> What is it about physicians and the medical profession that makes them so well-suited to assist individuals with dying? This question has received little attention in the literature, evidently because the answers are so obvious.

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342. *Compassion in Dying*, 850 F. Supp. at 1457 (quoting Dr. John P. Geyman, Professor Emeritus, University of Washington School of Medicine).

343. For further discussion of this point, see *infra* Part IV.A.3.

344. Even those who would find a constitutional right to assisted suicide acknowledge the power of a state to regulate the process. See Sedler, *supra* note 120, at 25 n.19 (suggesting that states would clearly have the constitutional power to regulate physician involvement in assisted suicide); see also *Compassion in Dying*, 850 F. Supp. at 1465 (stating that legislatures can devise regulations to define the appropriate boundaries of physician-assisted suicide); *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (“[W]e explicitly recognize that some prohibitory and regulatory state action is fully consistent with constitutional principles.”), *cert. granted sub nom. Washington v. Glucksberg*, 65 U.S.L.W. 3085 (U.S. Oct. 1, 1996) (No. 96-110). While these authorities discuss regulation in the context of assistance by physicians, a state could set up a different statutory scheme as long as it adequately effectuated individuals’ constitutional rights to assisted death. The state would, of course, be required to articulate rational reasons for such a statutory scheme. This would not be difficult given the problems inherent in physician participation, see *infra* Part IV.A.1-3, and the fact that others could be trained to provide competent assistance.

345. See Pellegrino, *supra* note 2, at 101; see also Bachman et al., *supra* note 320, at 303 (stating that it “seems likely that if any form of assisted suicide is legalized, legislators will want to entrust the responsibility of assistance to physicians”).

The two strongest arguments are physicians' knowledge and their power over the prescription process.<sup>346</sup> Physicians, through medical training and practice, acquire extensive knowledge of pharmaceutical agents, their appropriate uses, the physiological bases for their actions, and the recommended dosages to achieve the desired effects.<sup>347</sup> While doctors are not yet explicitly trained in the various pharmacological methods of causing death, they are certainly capable of using their medical knowledge to discern which drug or combination of drugs, when applied in lethal amounts, will produce a quick, painless death. Just as important, physicians are given by law access to the pharmacological means of death to the virtual exclusion of all others.<sup>348</sup>

In addition, if we intend to limit assisted death to the terminally ill and perhaps those with chronic, degenerative diseases who are in pain, the physicians who care for these individuals will already be an integral part of the process.<sup>349</sup> The preexisting relationship between physicians and their patients, and the fact that patients often turn to their physicians for relief of suffering, make them the logical choice to provide assistance here.<sup>350</sup> Doctors could quite naturally function as gatekeepers for assisted death because their diagnoses and prognoses will presumably determine which patients are entitled to assisted death.<sup>351</sup> The medical profession's ability to assess patients with regard to mental status and degree of pain and suffering would be useful in any regulatory scheme that required that qualified patients be both competent and in pain. Physicians could also determine whether these patients had received appropriate comfort care and palliative measures before turning to assisted death.<sup>352</sup> Thus, "doctors have the

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346. See Pellegrino, *supra* note 2, at 101.

347. See Bachman et al., *supra* note 320, at 303.

348. As one commentator noted, "[I]f physicians did not have a virtual monopoly on medications in this country, patients would not need to ask them for this kind of help." Abrams, *supra* note 279, at 1197.

349. See QUILL, *supra* note 8, at 126-27 (citing favorably Derek Humphry's view that doctors are well-situated to oversee this process because of their medical knowledge and preexisting relationships with their patients).

350. See Peter Steinfels, *At Crossroads U.S. Ponders Ethics of Helping Others Die*, N.Y. TIMES, Oct. 28, 1991, at A1 (quoting Cheryl K. Smith, staff attorney for the National Hemlock Society).

351. Each of the initiative proposals in Washington, California, and Oregon would have physicians function in precisely this manner. See *supra* Part II.B.

352. A number of proposals, including those of Dr. Timothy Quill, would require that individuals first exhaust all possible comfort- and hospice-care options before turning to assisted death.

technical expertise to make sure [assisted death] is being done only in the appropriate circumstances."<sup>353</sup> Because members of the medical profession are subject to control through state licensure and disciplinary processes, a mechanism already exists to oversee and regulate their actions in facilitating death.<sup>354</sup>

With all of these arguments in favor of physician-assisted death, why even imagine a system where the assistance is provided by some other group of trained individuals? The answers to this question are more subtle than the usual arguments against physician involvement and require a look at the nature of medical practice.

### 1. Medical Technology

Modern medical technology is frequently cast as the culprit in producing the unbearable distress that causes patients to want to end their lives.<sup>355</sup> Dr. Guy Benrubi, for example, argues that in the case of certain life-threatening cancers or other diseases, patients would die rapidly if there were no medical intervention.<sup>356</sup> Instead, with treatments such as chemotherapy, blood transfusions, radiation therapy, and surgical procedures, physicians are able to prolong individuals' lives from a few months to several years.<sup>357</sup> But at some point the medical technology inevitably fails and the patient's condition deteriorates, producing the potential for prolonged suffering. Dr. Benrubi argues that by prolonging life, the medical profession also prolongs agony, and then offers little or no help when the suffering becomes unbearable.<sup>358</sup> He likens the physician's refusal to aid the patient's death under these circumstances to that of a parent who encourages a child to climb higher and higher into a tree but then

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353. Richard A. Knox, *Poll: Americans Favor Mercy Killing*, BOSTON GLOBE, Nov. 3, 1991, at 1 (quoting Dan Brock, Director of the Center for Biomedical Ethics, Brown University).

354. *See id.*

355. *See, e.g.*, Preston, *supra* note 226, at 39 (suggesting that medical technologies have produced medical conditions that were unknown until the last few decades); Vaux, *supra* note 232, at 2141 (arguing that medical intervention has transformed death from an acute, natural, and noninterventional process into a more chronic, contrived, and manipulated process). *But see* Ezekiel J. Emanuel, *The History of Euthanasia Debates in the United States and Britain*, 121 ANNALS INTERNAL MED. 793, 799 (1994) (arguing that from an historical perspective, no causal link exists between advances in medical technology and societal interest in euthanasia).

356. *See* Benrubi, *supra* note 268, at 197.

357. *See id.*

358. *See id.*

refuses to help the child come down.<sup>359</sup> The argument is that physicians are culpable in bringing their patients to a state of unbearable agony and must therefore assist these individuals to die in order to exculpate themselves.<sup>360</sup>

I have three responses to the foregoing argument. First, I wonder whether we as a society are not engaging in a form of presentism when we assume that the pain and suffering we experience today is different in kind and degree than that suffered in ages past. Without discounting the very real pain and distress that are frequent companions of the present-day dying process, I doubt that women who died in the throes of childbirth, or persons who died of bubonic plague, or tetanus poisoning experienced painless, dignified deaths. Acknowledging that death accompanied by pain and suffering was the rule even before the explosion in medical technology does not answer the question whether physician-assisted death is an appropriate response, but it does suggest that we need to move beyond such self-referential justifications.

Second, it is surprising and a bit ironic that in this age of individual and patient autonomy we revert so quickly to the position that the physician is responsible for what the law would tell us is the patient's choice to rely on medical technology. Surely we would not label as irrational a decision by a well-informed patient to undergo life-prolonging treatment with the knowledge that she may suffer more pain and distress when the technology can no longer sustain her life.

But perhaps I have it wrong. Perhaps physicians exercise a significant amount of control over the medical decision-making process so that patients are routinely subjected to technological invasions that are more a reflection of the physician's power than the patient's choice. But this leads to my third point and the ultimate irony in this debate. If the decision to use technology is in reality the physician's, and if physicians misuse their power (as is implied by the argument that they are responsible for their patients' pain and suffering), then how can we in good conscience propose, in the name of individual autonomy, a solution that hands the medical profession even more power over their patients' lives?

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359. *See id.*

360. *See id.* at 197-98. *See also* Preston, *supra* note 226, at 39; Vaux, *supra* note 232, at 2141.



## 2. Medical Decisionmaking

For hundreds of years, physician beneficence was the guiding principle of medical ethics.<sup>361</sup> However, beneficence in the medical setting was translated into something more than a duty to provide benefit to patients and prevent harm; it became a license to decide what was best for patients because they supposedly lacked the expertise and knowledge to make medical decisions for themselves.<sup>362</sup> It was not until the 1960s that medical paternalism in the guise of beneficence was exposed and renounced, first by the legal community and more slowly by the medical community.<sup>363</sup> Today, patient autonomy is heralded as the dominant principle shaping medical ethics and the physician-patient relationship.<sup>364</sup>

Although the principle of individual autonomy has attained primacy over physician beneficence at the theoretical level, very real questions remain as to whether or how the principle of autonomy has been translated into day-to-day medical practice. Dr. Jay Katz, a renowned expert on the doctrine of informed consent and a vehement critic of the medical profession in this regard,<sup>365</sup> recently summarized his thoughts and conclusions on the doctrine of informed consent and its impact on the physician-patient relationship.<sup>366</sup> He argues convincingly that informed consent today is "largely a charade which misleads patients into thinking that they are making decisions when indeed they are not."<sup>367</sup> He challenges the notion that physicians have internalized the principle of patient autonomy beyond the most superficial of levels, and contends that informed consent will remain a "fairy tale" until this commitment to autonomy becomes an integral aspect of the medical ethos.<sup>368</sup>

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361. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 209 (3d ed. 1989).

362. See Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 50-51 (1994).

363. See Jay Katz, *Informed Consent—Must It Remain a Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 77 (1994).

364. See Pellegrino, *supra* note 362, at 47.

365. Dr. Katz is the Elizabeth K. Dollard Professor Emeritus of Law, Medicine, and Psychiatry at Yale Law School, and the author of the celebrated book *The Silent World of Doctor and Patient*. In his book, he describes the history of the doctor-patient relationship and strongly criticizes the medical profession's failure to engage in shared decisionmaking with patients. See JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

366. See Katz, *supra* note 363.

367. *Id.* at 84.

368. See *id.* at 87-91.

A number of recent medical studies on end-of-life decisionmaking support Katz's rather pessimistic view of the current state of affairs.<sup>369</sup> One prospective study analyzed the correlation between patients' wishes as expressed in advance directives and the subsequent medical treatment given those patients.<sup>370</sup> The researchers found that in approximately seventy-five percent of cases, treatment was consistent with patients' wishes as recorded in the advance directives.<sup>371</sup> While this figure is not highly disturbing on its face, it is not entirely reassuring either. The authors allude to the fact that when physicians made decisions contrary to those expressed in the advance directives, they frequently did so by applying principles other than patient autonomy.<sup>372</sup> One commentator has gone further, suggesting that the study reveals that physicians will follow patient preferences as long as those preferences are consistent with the physicians' own views on appropriate medical care, and that doctors will override patients' wishes when they disagree with their choices.<sup>373</sup>

In a study of the withholding and withdrawing of medical treatment from the critically ill, researchers analyzed decisionmaking for individuals in intensive care units in two San Francisco hospitals over a one-year period.<sup>374</sup> In the seven percent of the cases in which life support was withheld or withdrawn, physicians, rather than patients or family members, initiated the issue of withholding or withdrawal of care in the vast majority of cases.<sup>375</sup> When families were consulted, ninety-one percent of them agreed immediately with the medical recommendation to withhold or withdraw care, and an additional seven percent of families agreed with the recommendation after two or three days of discussion and deliberation.<sup>376</sup> While this study can be read to signify the high degree of concordance between physician and patient or family views on end-of-life decisions, it may also reflect the degree of influence physicians have over both the

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369. For an excellent discussion of this topic, see David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101, 2101 (1992).

370. See Marion Danis et al., *A Prospective Study of Advance Directives for Life-Sustaining Care*, 324 NEW ENG. J. MED. 882 (1991).

371. See *id.* at 884.

372. See *id.* at 887.

373. See Orentlicher, *supra* note 369, at 2101. Dr. Orentlicher would interpret the 75% figure as encompassing those circumstances where physicians agreed with the choices made by their patients.

374. See Nicholas G. Smedira et al., *Withholding and Withdrawal of Life Support from the Critically Ill*, 322 NEW ENG. J. MED. 309 (1990).

375. See *id.* at 311.

376. See *id.* at 312.

decision-making process and the ultimate decisions. As Edmund Pellegrino recently stated, "[A]ny clinician knows, she can get almost any decision she wants from most patients."<sup>377</sup>

In a recent Canadian study, a group of researchers specifically set out to explore whether the attitudes and values of health care providers influence decisionmaking in withdrawal-of-life-support cases.<sup>378</sup> In an era of patient autonomy, one might expect that such decisions would be dictated by patients' and their families' values and preferences. The study's authors turned that assumption on its head by suggesting that it is the health-care providers' attitudes and values that are critical factors in the decision-making process. They posited that physicians and other health care providers use their own attitudes and values in shaping and presenting the information given to patients and their families, which in turn strongly influences patients' preferences and choices.<sup>379</sup> The study was designed to assess the variables that influence health care providers' decisions in withdrawal-of-life-support cases. The researchers first asked intensive care unit physicians and nurses to rank in order of importance various factors in treatment-withdrawal cases, including likelihood of long term survival, patient age, socioeconomic status, and risk of legal complications.<sup>380</sup> The authors then asked the respondents to make hypothetical treatment decisions in each of twelve detailed life-support scenarios.<sup>381</sup> Despite the fact that respondents generally agreed on the relative importance of the withdrawal-of-life-support factors in the abstract,<sup>382</sup> their responses to the twelve scenarios revealed striking variability in whether and to what extent life support should be withdrawn.<sup>383</sup> After performing

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377. Pellegrino, *supra* note 362, at 55.

378. See Deborah J. Cook et al., *Determinants in Canadian Health Care Workers of the Decision to Withdraw Life Support from the Critically Ill*, 273 JAMA 703 (1995).

379. See *id.* at 704.

380. See *id.* Respondents were asked to rank in order of importance 19 potential determinants of life support, using a scale ranging from one (completely irrelevant) to seven (extremely important). See *id.*

381. See *id.* In order to avoid confusion due to such variables as patient and family preferences, the authors constructed scenarios in which the hypothetical patients were unable to assist in decisionmaking and family and friends were unavailable. See *id.* The respondents were asked to choose from among five levels of care that ranged from aggressive management to comfort measures only. See *id.* at 704.

382. See *id.* at 706. Within the physician and nurse groups, the correlation for 17 of the factors ranged from 0.68 to 0.96. See *id.* at 704. Two factors, those of sex and sexual orientation, were deleted because almost all respondents ranked them as having little importance. See *id.*

383. See *id.* at 706. This variability was reflected in the fact that in only one of the scenarios did more than 50% of the respondents choose the same treatment course. See *id.*

statistical analyses, the study's authors determined that the marked variability in responses could only be explained by factors or characteristics intrinsic to the individual health-care providers.<sup>384</sup> From this, the researchers concluded that "even when clinicians make decisions based on the best evidence available, their own ethical, social, moral, and religious values influence their medical decisionmaking."<sup>385</sup>

In another study, a group of researchers conducted a survey of health-care professionals on the subject of end-of-life decisionmaking.<sup>386</sup> The questionnaire covered a range of issues including knowledge and attitudes regarding the law and medical ethics, knowledge of and adherence to institutional guidelines on the use of life support, clinical practices in the use of life support, patient involvement in decisionmaking, and perceived impediments to good decisionmaking and quality care.<sup>387</sup> Although most of the physicians and nurses recognized patients' rights to refuse care, they also reported that they sometimes ignored their patients' wishes and provided inappropriate and overly burdensome care.<sup>388</sup> Similarly, in a survey of critical-care medicine specialists, thirty-four percent of the doctors reported having refused patient or family requests to discontinue life support,<sup>389</sup> and thirty-five percent reported having withdrawn life support either without the knowledge or without the formal consent of the patient or the patient's family.<sup>390</sup> Whatever the reasons behind such actions,<sup>391</sup> the fact that physicians in high numbers report ignoring their

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384. *See id.*

385. *Id.* at 708.

386. *See* Mildred Z. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 AM. J. PUB. HEALTH 14 (1993); *see also* Jane E. Brody, *Doctors Admit Ignoring Dying Patients' Wishes*, N.Y. TIMES, Jan. 14, 1993, at 18. The survey was conducted through a 123-item questionnaire and was completed by approximately 1,400 physicians and nurses at five hospitals in various parts of the country. *See* Solomon et al., *supra*, at 15.

387. *See id.* at 15.

388. *See id.* at 16-17. A high percentage of respondents reported dissatisfaction with the level of patient involvement in treatment decisions, suggesting that they were concerned with the lack of patient input in end-of-life decisions. *See id.* at 16.

389. *See* David A. Asch et al., *Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians' Practices and Patients' Wishes*, 151 AM. J. RESPIRATORY & CRITICAL CARE MED. 288, 290 (1995). The survey was mailed in 1990 to all 1,970 members of the Critical Care Section of the American Thoracic Society; 1,050 physicians responded, a 53% response rate. *See id.* at 289.

390. *See id.* at 291 tab. 6.

391. *See* Asch et al., *supra* note 389, at 290 tab. 4 (listing reasons why physicians refused patient or family requests to withdraw life-sustaining treatment); Solomon et al.,

patients' wishes and substituting their own values in end-of-life decisions should give us pause.

Although these studies clearly suggest that physicians use their power in the physician-patient relationship to either make or influence end-of-life decisions, such studies do have inherent limitations. For example, physician surveys may reveal more about what physicians think they do than what they do in actual practice, while chart reviews that document end-of-life decisions still leave unilluminated the dynamics of the decision-making process itself. Fortunately, researchers have recently begun to focus their attention on the process of medical decisionmaking within the clinical setting.

The SUPPORT study, published in 1995, is a groundbreaking piece of research in this area.<sup>392</sup> In an effort to improve the process of end-of-life decisionmaking, the researchers first documented the decision-making processes among medical staff and their terminally ill patients in five teaching hospitals over a two-year period.<sup>393</sup> They gathered baseline information, including whether patients wanted aggressive treatment such as cardiopulmonary resuscitation (CPR) and mechanical ventilation, the percentage of physicians who could accurately recount their patients' wishes, the type of treatments physicians actually provided, and the degree of pain experienced by patients before they died.<sup>394</sup> They then carried out a two-year controlled clinical trial in these same hospitals to see if intervention in the decisionmaking process would lead to improved physician-patient communication and end-of-life decisionmaking.<sup>395</sup>

Phase I, the observational portion of the study, revealed that even though these patients were known to be dying and in many cases were hospitalized for extended periods, physicians frequently failed to discuss end-of-life decisions with them until shortly before their

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*supra* note 386, at 19-20 (discussing possible causes including health care provider uncertainty about the law and ethics on withdrawal of treatment, inadequate communication between physicians and patients, psychological discomfort with withdrawing treatment once it has begun, and discomfort with withholding or withdrawing artificial nutrition).

392. See The SUPPORT Principal Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). "SUPPORT" is an acronym for the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment. See *id.*

393. See *id.* The researchers collected data through interviews with the hospitalized patients or their surrogate decisionmakers and with the patients' physicians. See *id.* at 1592.

394. See *id.* at 1593; see also Susan Gilbert, *Study Finds Doctors Refuse Patients' Requests on Death*, N.Y. TIMES, Nov. 22, 1995 at A1 (reporting on the SUPPORT study).

395. See The SUPPORT Principal Investigators, *supra* note 392, at 1593.

deaths.<sup>396</sup> Families reported that half of the patients who were able to communicate spent their final days in moderate or severe pain.<sup>397</sup> Thirty-one percent of the patients preferred that CPR be withheld, but only forty-seven percent of their physicians could accurately recount this preference.<sup>398</sup> Physicians failed to write DNR orders for forty-nine percent of the patients who expressed a desire to have CPR withheld.<sup>399</sup> Half of the dying patients spent their final days in the intensive care unit comatose or receiving mechanical ventilation.<sup>400</sup>

Having documented what they described as "substantial shortcomings in communication and outcomes,"<sup>401</sup> the researchers embarked on Phase II, the interventional portion of the study. Skilled nurses met daily with hospitalized terminally ill patients or their families to discuss their wishes for treatment and then relayed this information to the attending physicians. These same nurses, through the aid of a computer program, also provided physicians with their patients' chances of surviving six months and estimates of their future functional abilities.<sup>402</sup> The nurses concurrently provided services to the dying patients in the form of eliciting their treatment preferences; providing information and enhancing patient understanding; arranging meetings between physicians, patients, and their families; and facilitating palliative care.<sup>403</sup>

If the study's authors were concerned by the results of Phase I, they were even more dismayed by their findings in Phase II. The intensive intervention, designed to improve information, enhance conversation, and encourage use of outcome data and patient preferences in decisionmaking, had no discernible effect on end-of-life decisionmaking.<sup>404</sup> The treating physicians were no better at stating their patients' preferences with regard to treatment, desired DNR orders still went unwritten, and dying individuals languished in pain in

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396. *See id.* at 1595.

397. *See id.*

398. *See id.* at 1594.

399. *See id.*

400. *See id.* at 1595.

401. *Id.* at 1592.

402. *See id.*

403. *See id.*

404. *See id.* at 1596. To reach this conclusion, the study compared the following data before and after intervention: median time until desired DNR orders were written, physician understanding of patient preferences, median length of time patients spent in intensive care units while comatose or receiving mechanical ventilation, patient reports of pain, and health care resource use. *See id.* at 1594-96 & tab. 4.

the intensive care units at the same rate as before the intervention.<sup>405</sup> The authors, clearly troubled by these findings, concluded the report with the following observation:

The picture we describe of the care of seriously ill or dying persons is not attractive. One would certainly prefer to envision that, when confronted with life-threatening illness, the patient and family would be included in discussions, realistic estimates of outcome would be valued, pain would be treated, and dying would not be prolonged. That is still a worthy vision. However, it is not likely to be achieved through an intervention such as that implemented by SUPPORT.<sup>406</sup>

If patient preferences and prognoses are not driving end-of-life decisionmaking, what is? Professor Robert Zussman, in his book *Intensive Care: Medical Ethics and the Medical Profession*, provides critical insights into the medical decision-making process.<sup>407</sup> He criticizes modern medical ethics commentators for concentrating on questions of how medical decisions *should* be made to the exclusion of examining how they are *actually* made in practice.<sup>408</sup> By conducting extensive field research in the intensive care units of two teaching hospitals,<sup>409</sup> he begins to bridge the gap between knowledge of medical ethics principles and their actual implementation by physicians.

Professor Zussman makes a number of interesting points, but, for our purposes, the most important is his observation that physicians seem to inhabit two different worlds: the culture of patients' rights and the culture of the ward.<sup>410</sup> The culture of rights arises from bioethics, law, and social policy; it validates individual patient autonomy.<sup>411</sup> The culture of the ward arises from the socialization of physicians through training and practice; it validates physician authority and discretion.<sup>412</sup> A great tension obviously exists between these two cultures. Professor Zussman found that physicians navigate between the two cultures by turning to the culture of rights when discussing general ethical principles, but reverting to the culture of the

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405. See *id.* at 1595.

406. *Id.* at 1597 (footnotes omitted).

407. ROBERT ZUSSMAN, *INTENSIVE CARE: MEDICAL ETHICS AND THE MEDICAL PROFESSION* (1992).

408. See *id.* at 1-2.

409. See *id.* at 15-16. Professor Zussman did his field work at a New York City hospital between 1985 and 1987, and at a Boston hospital in 1989. See *id.* at 26.

410. See *id.* at 222-24.

411. See *id.* at 9-12.

412. See *id.* at 112.

ward when making decisions in particular cases.<sup>413</sup> In other words, physicians acknowledge that patients have the right to make medical treatment decisions in the abstract, but in practice frequently arrogate decision-making power to themselves.<sup>414</sup> Professor Zussman does not see their actions as hypocritical, but rather as an understandable attempt to function professionally within two competing and conflicting cultures.<sup>415</sup>

The ways in which physicians make decisions for their patients are many and varied. Physicians actively shape their patients' wishes by framing information and controlling choices so that patients or their families end up "choosing" the course of action desired by their doctors.<sup>416</sup> Professor Zussman relates one incident where a resident physician forestalled discussion with a family about whether they wished kidney dialysis for their relative by stating, "First, we have to decide what we want to do. . . . It depends on how we present it."<sup>417</sup> To which the attending physician responded, "The family will do what we want."<sup>418</sup> Physicians frequently label the question in a particular case as one of technique, requiring medical expertise, rather than one of values falling within the patient's domain.<sup>419</sup> In addition, they may narrow the scope of alternatives presented to the patient<sup>420</sup> and discount or ignore families' wishes because of the family members' emotional involvement.<sup>421</sup> Professor Zussman summarizes physicians' actions as follows:

Although courts, state law, and hospital policies are all virtually unanimous in their insistence that decisions to limit treatment be made by patients . . . I have argued that decisions are, in fact, as often (or more often) made by physicians. Unable to evaluate the course of a disease or the possibility of treatment on their own, patients and their families rely on the technical judgment of physicians. But the judgment of physicians in these matters is not simply technical. It is also shaped by their own interests and by adaptations to the stresses of medical practice, as well as by apparently high-minded concerns that

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413. See *id.* at 224.

414. For example, Professor Zussman described one incident in which a resident physician first stated, "the decision is not mine—whose treatment should be withdrawn, who should be code or no-code," but then proceeded to make the decision anyway. *Id.*

415. See *id.* at 152-53.

416. See *id.* at 142-44.

417. *Id.* at 143.

418. *Id.*

419. See *id.* at 141-51.

420. See *id.* at 147-48.

421. See *id.* at 144-45.



are at best ambiguously patient centered. Whether physicians report a patient as "terminal" or the possibility of recovery "realistic" does involve technical judgment, but technical judgment shaped by the distinctive values of their occupation.<sup>422</sup>

Such empirical findings are surely relevant in the context of deciding whether physicians are the proper individuals in whom to place the power over assisted death. Some bioethicists suggest that the option of physician-assisted death would help dying patients break free from the vicious cycle of treatment and torment. They argue that the recategorization of death as a good, or at least acceptable, outcome under certain circumstances is long overdue and a much needed change from the current medical emphasis on sustaining life. However, that is only true if each individual is allowed the opportunity to decide for herself whether and when death is an acceptable outcome. This is a questionable proposition in the context of physician-assisted death where medical providers hold such power over the decision-making process. As one commentator asserted, the ways in which a physician frames medical facts and treatment options "are often subtly or frankly conditioned by [the physician's] judgment of what she thinks is in the patient's best interests."<sup>423</sup> The principles of individual and patient autonomy that form the foundation for physician-assisted death are seriously undercut by the power differential in the physician-patient relationship and the fact that physicians can so easily influence their patients' choices.<sup>424</sup>

It is worth examining the kinds of influence physicians might exert in the context of assisted death. First, members of the medical profession could conceivably use their power in the medical decision-making process to bring about assisted deaths that individuals would not otherwise have chosen. Supporters of physician-assisted suicide might argue that this scenario is very unlikely because the studies suggest that when physicians do substitute their own values for those of their patients, they tend to preserve life at all costs rather than bring about unwished-for deaths. Thus, far from embracing physician-assisted death, perhaps physicians would err on the side of life and turn to assisted suicide only as a last resort.

There is another possibility, however. Howard Brody, in his book *The Healer's Power*, develops the thesis that modern ethical

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422. *Id.* at 221.

423. Pellegrino, *supra* note 362, at 55.

424. *See id.*

theory fails to adequately describe the physician-patient relationship and the nature of medical decisionmaking because it fails to take into account the various forms of power wielded by members of the medical profession.<sup>425</sup> Particularly relevant for our purposes is Brody's examination of something he terms the "rescue fantasy."<sup>426</sup> The rescue fantasy incorporates a vision of the physician as an all-powerful individual who, by virtue of his or her medical knowledge and expertise, is able to "snatch the patient from the jaws of death."<sup>427</sup> While the rescue fantasy is a throwback to an earlier era, Brody argues that it continues to thrive in modern-day medicine within the minds of physicians and their patients.<sup>428</sup> It thrives, despite our supposed rejection of medical paternalism and our endorsement of individual autonomy, because physicians, from the day they begin medical training, define their worth as doctors and perhaps as individuals on the basis of their ability to control bad outcomes.<sup>429</sup> Thus, Brody would explain certain medical treatment decisions as resulting from physicians' powerful need to rescue their patients, particularly from the ultimate bad outcome, death.

Consistent with Brody's thesis, Sherwin Nuland, physician and author of the influential book *How We Die*, describes doctors as intensely controlling individuals who fear failure, particularly in their professional lives.<sup>430</sup> He adds an additional but related concept that he terms the "Riddle." The "Riddle" is the quest by physicians to diagnose and cure disease; Nuland describes it as the most powerful and defining image in medicine.<sup>431</sup> The desire to successfully solve the "Riddle" drives physicians to such an extent that they sometimes subordinate individual patient welfare to their own self-fulfillment.<sup>432</sup> According to Nuland, this quest to succeed is what causes physicians

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425. See HOWARD BRODY, *THE HEALER'S POWER* 26-43 (1992). Howard Brody is a family practice physician and Director of the Center for Ethics and Humanities in the Life Sciences at Michigan State University. See *id.* at xii.

426. See *id.* at 137-56. Brody credits Dr. Albert Jonsen and modern psychology for the origins of this term. See *id.* at 137.

427. *Id.* at 139.

428. See *id.* at 140. Brody suggests that patients engage in the rescue fantasy when they wish to transfer to someone else the responsibility for health or sickness and receive reassurance. See *id.* at 141.

429. See *id.* at 139-40.

430. See SHERWIN B. NULAND, *HOW WE DIE* 258 (1994). Nuland describes physicians as highly competitive individuals by nature who require constant reassurance of their abilities in order to maintain their sense of self worth. See *id.*

431. See *id.* at 248.

432. See *id.* at 248-49.

to convince terminally ill patients to undergo incredibly burdensome and even futile diagnostic and therapeutic measures.<sup>433</sup>

If we combine Brody's "rescue fantasy" and Nuland's "Riddle," it is possible to construct a scenario in which physicians come to embrace the concept of assisted death to a surprising degree.<sup>434</sup> Physicians need to rescue their patients in order to retain their own sense of professional and personal self-worth, and they do so by pushing treatment and technology on patients in an attempt to solve the riddle of disease. But even physicians realize at some point that rescue is impossible, and so they abandon the dying patient in order to avoid facing the defeat that the patient's death represents.<sup>435</sup> The individual is thus left alone to face certain death preceded by unbearable pain and suffering.<sup>436</sup> Now, if we add the power to assist death to the physician's technological armamentarium, the picture changes. While the intent is to effectuate patient autonomy at the end of life, the addition of this power actually provides physicians with the perfect solution to the dilemma posed by the rescue fantasy: that sometimes rescue is impossible. Physician-assisted death thus comes to the *physicians' rescue* by eliminating their defeat at the hands of their patients' deaths.<sup>437</sup> Rescue is no longer confined to cure; it now includes providing a painless, dignified death.

The inclusion of physician-assisted death in the rescue fantasy changes physician incentives and may actually exacerbate the problems posed by doctors' use of technology in attempting to defeat disease. With assisted death as one of their options, physicians might redouble their efforts, including the use of technology, to combat disease even in cases where the prognoses are dim and the patients hesitant. Doctors can use their power over assisted death to convince patients that they have nothing to lose in fighting the battle with every

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433. See *id.* at 249.

434. My point is counterintuitive in the sense that up until now, the combination of the rescue fantasy and the Riddle has produced an incentive among physicians to *sustain* life, not to end it.

435. See NULAND, *supra* note 430, at 258 (stating that physicians' inability to face the consequences presented by loss of control leads them to turn away from situations where their power is of no use).

436. Of course, the scenario I have just constructed by combining the rescue fantasy and the Riddle is the very same one that assisted-death advocates use in their arguments. See *supra* notes 293-302 and accompanying text.

437. On a related note, some commentators have suggested that physicians might use assisted death as a way to put an end to their own frustrations and burdens in caring for terminally ill patients. See Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786, 1786 (1994); Pellegrino, *supra* note 274, at 874-75.

medical means possible because if things get too bad, they can always choose a quick and painless death. Thus, physician-assisted death not only becomes a part of the rescue fantasy; it also plays into the medical profession's quest to solve the "Riddle." The ultimate irony in this entire process is that the very same individuals and political organizations who have fought so hard to wrest control over death away from the medical profession and return it to individuals are now willing to hand that control back to the medical profession, and they do so in the name of individual autonomy.<sup>438</sup>

Having suggested that physicians might embrace assisted suicide in ways that ought to give us pause, I will now propose the opposite, but equally problematic, possibility. Rather than imposing their own value judgments to convince individuals to turn to assisted death, perhaps physicians will use their power in the decision-making process to deny individuals access to assisted death even where those persons meet all of the statutory requirements and have expressed their desire to die.

Dr. Timothy Quill's proposal of clinical guidelines for physician-assisted suicide provides a useful example in this regard.<sup>439</sup> He and two colleagues developed and published these clinical criteria approximately a year and a half after Quill divulged his role in the death of his patient Diane.<sup>440</sup> The guidelines are preceded by a general discussion in which Quill and his colleagues explain their decision to support the legalization of physician-assisted suicide but not voluntary euthanasia.<sup>441</sup> They justify the distinction between the two by suggesting that the "risk of subtle coercion from doctors, family members, institutions, or other social forces is greatly reduced" when the patient performs the final act.<sup>442</sup> In their opinion, the balance of power between the physician and patient is more nearly equal when the doctor acts as counselor and witness and provides the means but does not perform the final act. In contrast, they contend that when the physician provides the means and the ends, so to speak, the physician wields so much power over the patient that the risk of error, coercion,

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438. One ethicist has argued that it is illogical to suggest that the natural-death movement and its skepticism toward medical technology lend support to the use of lethal injections, which are after all a form of technology, to cause death. See Giles R. Scofield, *Euthanasia [Letter]*, 321 NEW ENG. J. MED. 120, 120 (1989).

439. See Quill et al., *supra* note 268.

440. See *supra* Part III.A.4.

441. See Quill et al., *supra* note 268, at 1381.

442. See *id.*

or abuse is unacceptably high.<sup>443</sup> Quill and his coauthors also explained that they view physician-assisted suicide as a last resort rather than a substitute for comfort care or for working with patients to resolve the varied challenges posed by the dying process.<sup>444</sup>

The proposed seven "Clinical Criteria for Physician Assisted Suicide," are as follows:

1. [T]he patient must have a condition that is incurable and associated with severe, unrelenting suffering. The patient must understand the condition, prognosis, and the types of comfort care available as alternatives.<sup>445</sup>
2. [T]he physician must ensure that the patient's suffering and the request are not the result of inadequate comfort care. All reasonable comfort-oriented measures must at least have been tried, before the means for a physician-assisted suicide are provided.<sup>446</sup>
3. [T]he patient must clearly and repeatedly, of his own free will and initiative, request to die rather than continue suffering. The physician should understand thoroughly what continued life means to the patient and why death appears preferable. . . . Any sign of ambivalence and uncertainty on the part of the patient should abort the process, because a clear, convincing, and continuous desire for an end of suffering through death is a strict requirement to proceed.<sup>447</sup>
4. [T]he physician must be sure that the patient's judgment is not distorted. The patient must be capable of understanding the decision and its implications. The presence of depression is relevant if it is distorting rational decision making and is reversible in a way that would substantially alter the situation. Expert psychiatric evaluation should be sought when the primary physician is inexperienced in the diagnosis and treatment of depression, or when there is uncertainty about the rationality of the request or the presence of a reversible mental disorder the treatment of which would substantially change the patient's perception of his or her condition.<sup>448</sup>
5. [P]hysician-assisted suicide should be carried out only in the context of a meaningful doctor-patient relationship. Ideally, the physician should have witnessed the patient's previous illness and suffering. There may not always be a preexisting relationship but the physician must get to know the patient personally in order to understand fully the reasons for the request. . . . Rather than create a new sub-specialty

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443. *See id.*

444. *See id.* at 1380.

445. *Id.* at 1381.

446. *Id.* at 1382.

447. *Id.*

448. *Id.*

focused on death, assistance in suicide should be given by the same physician who has been struggling with the patient to provide comfort care, and who will stand by the patient and provide care until the time of death, no matter what path is taken.<sup>449</sup>

6. [C]onsultation with another experienced physician is required to ensure that the patient's request is voluntary and rational, the diagnosis and prognosis accurate, and the exploration of comfort-oriented alternatives thorough.<sup>450</sup>

7. [C]lear documentation to support each condition is required. A system must be developed for reporting, reviewing, and studying such deaths and clearly distinguishing them from other forms of suicide.<sup>451</sup>

Quill's proposal is interesting for a number of reasons. First, the guidelines appear to be an almost perfect description of the Diane case. One way of viewing these clinical criteria, then, is as an elaborate justification for Dr. Quill's own actions. Second, the guidelines are quite limiting on the question of who is entitled to assisted death. For example, dying persons would not be entitled to assistance if they expressed *any* ambivalence in the decision-making process.<sup>452</sup> They must have a condition that is associated with severe, unrelenting suffering,<sup>453</sup> and must have tried comfort care measures before they can qualify for assisted death.<sup>454</sup> It is insufficient to be terminally ill and want to die. Third, the guidelines are extremely physician-centered. The physician must get to know the patient; the physician must understand the reasons for the request; the physician should understand what continued life means to the patient; the physician should have witnessed the patient's previous suffering. One gets the sense that the patient who desires assistance carries the burden of convincing the physician that he or she is *worthy* of the doctor's help.

As if these guidelines were not sufficiently physician-centered, a subsequent proposal, in which Dr. Quill also played a role, would give the medical profession even greater control.<sup>455</sup> Under this proposal, case-specific oversight of decisions to utilize assisted death would be provided by "palliative-care consultants." These palliative-care consultants would be physicians (who else?) trained in the care of the

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449. *Id.*

450. *Id.*

451. *Id.*

452. See *supra* note 447 and accompanying text. This requirement is patently absurd. Ambivalence in this context is not only understandable, it is rational and expected.

453. See *supra* note 445 and accompanying text.

454. See *supra* note 446 and accompanying text.

455. See Miller et al., *supra* note 268, at 119.

dying, educated in ethics, and skilled in the assessment of decision-making capacity of patients.<sup>456</sup> Their oversight responsibilities would include reviewing medical records and interviewing the treating physician, patient, and interested family members.<sup>457</sup> Incredibly, the certified palliative-care consultant would have the authority to override the individual and treating physician's decision to go forward with assisted death.<sup>458</sup>

It ought to be clear by now that the proposals emanating from the medical profession bear little resemblance to Washington's Initiative 119, California's Proposition 161, or Oregon's Ballot Measure 16. If you look closely at them, the reason for the difference becomes clear: the medical profession's proposals are derived from a physician-beneficence rather than an individual-autonomy model. They are designed first and foremost to protect the interests of the medical profession in this process, and patients are entitled only to that which physicians think is in their best interests, nothing more.

While it is entirely likely that such proposals will never become law, their very existence ought to concern supporters of assisted death. If physicians control this process, it does not matter how liberal or autonomy-based the statutory framework for assisted death is; the medical profession will translate that framework into something more consonant with the medical beneficence model. Furthermore, when deciding what is in the best interests of their terminally ill patients, physicians will inevitably use their own values, albeit couched in terms of medical expertise and judgment. Professor Zussman described this very phenomenon when he observed that physicians at the New York hospital he studied were more cautious about limiting treatment for dying patients than physicians at the Massachusetts hospital, and that this difference in treatment between hospitals occurred because physicians used different definitions for the word "terminal."<sup>459</sup> Professor Zussman stated, "In this difference—masked by the language of prognosis and diagnosis, by the results of laboratory tests and probability estimates—is the open moral space of American

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456. *See id.* at 121.

457. *See id.*

458. *See id.* They would have the right to appeal to a regional palliative-care committee, made up of professional and lay members. *See id.*

459. *See* ZUSSMAN, *supra* note 407, at 131-33.

medicine. It is a space quickly filled with physicians' values."<sup>460</sup> For purposes of my analysis, it matters little whether physicians are more likely to use their power in the physician-patient relationship to facilitate or to prevent assisted deaths. The point is that they will control the process, and their values will dictate the results.

### 3. The Nature of Medical Training

Perhaps commentators' seeming willingness to overlook the risks to individual autonomy from physician participation in assisted death arises from a societal belief that members of the medical profession possess expertise not just in technical medical matters, but in ethical and moral ones as well. It is important to examine whether deference in such matters is justified because it is clear that physicians will not shrink from exercising power in the moral realm if the community cedes it to them:

With our technologies, we are forever leading our patients into dilemmas that are inherently social and nonmedical, and increasingly we shall need to help them in nonhealing ways.<sup>461</sup> Physicians may have no special expertise in making these social, end-of-life decisions, but we are the only ones who can help patients with them . . . .<sup>462</sup>

Are physicians qualified by virtue of their medical training to claim expertise and authority in the realm of the nonmedical? In answering this question, it is useful to briefly examine two related aspects of medical training: education in ethics and education in empathy.

One would expect that contemporary physicians would be experts in medical ethics. They confront ethical dilemmas on virtually a daily basis.<sup>463</sup> However, formalized ethics training within medical school curricula is relatively new, with the result that most practicing physicians have had little or no formal schooling in medical ethics theory and its application. Further, although accrediting guidelines have been recently revised to require all medical schools to provide

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460. *Id.* at 133. When Professor Zussman speaks of "physicians' values," he refers not to the philosophical sort but rather the basic assumptions, orientations, and concerns that are central to the medical profession as a profession. *See id.* at 46.

461. Preston, *supra* note 226, at 39. Dr. Preston is a physician and outspoken advocate of physician-assisted death.

462. *Id.* at 40.

463. *See* Edmund D. Pellegrino et al., *Relevance and Utility of Courses in Medical Ethics: A Survey of Physicians' Perceptions*, 253 JAMA 49, 52 (1985).



ethics courses,<sup>464</sup> the content, quality, and quantity of ethics courses and clinical experiences vary considerably from one school to the next.<sup>465</sup>

Even with the move toward incorporating medical-ethics education into the curriculum, there are indications that training falls considerably short of what is needed. In a recent essay contest, medical students were asked how they could best develop ethical thinking and behavior.<sup>466</sup> Through their essays, students called for ethics teaching to be incorporated into all four years of medical school, but particularly within the third and fourth clinical years, where too often they are "left to themselves to puzzle out the right and the good."<sup>467</sup> The students yearned for ongoing relationships with physicians who could mentor them and provide guidance when ethical dilemmas arose.<sup>468</sup> Perhaps the most disturbing aspect of the essay contest was the number of medical students who expressed the view that medical training actually reduces their ethical sensitivity and damages their moral development.<sup>469</sup> These students expressed considerable doubt over the extent to which they would be able to retain their own humanity as they underwent the medical socialization process.<sup>470</sup>

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464. See Cheryl P. Weinstock, *Adding a Personal Touch to Medicine*, N.Y. TIMES, May 2, 1993, § 13LI, at 4.

465. See, e.g., David Barnard & K. Danner Clouser, *Teaching Medical Ethics in Its Contexts: Penn State College of Medicine*, 64 ACAD. MED. 744 (1989); James F. Bresnahan & Kathryn Montgomery Hunter, *Ethics Education at Northwestern University Medical School*, 64 ACAD. MED. 740 (1989); Baruch A. Brody, *The Baylor Experience in Teaching Medical Ethics*, 64 ACAD. MED. 715 (1989); Loretta M. Kopelman, *Development of the Medical Humanities Program at East Carolina University*, 64 ACAD. MED. 730 (1989); Donnie J. Self et al., *The Effect of Teaching Medical Ethics on Medical Students' Moral Reasoning*, 64 ACAD. MED. 755 (1989).

466. See Rita Charon & Renee C. Fox, *Critiques and Remedies: Medical Students Call for Change in Ethics Teaching*, 274 JAMA 767, 771 (1995); see also Michael Sanders, *The Forgotten Curriculum: An Argument for Medical Ethics Education*, 274 JAMA 768, 769 (1995) (asserting that students receive little ethics training during their clinical rotations).

467. Charon & Fox, *supra* note 466, at 771.

468. See *id.* at 767; see also Roxanne B. Sukol, *Teaching Ethical Thinking and Behavior to Medical Students*, 273 JAMA 1388, 1388 (1995).

469. See Charon & Fox, *supra* note 466, at 767; see also Chris Feudtner et al., *Do Clinical Clerks Suffer Ethical Erosion? Students' Perceptions of Their Ethical Environment and Personal Development*, 69 ACAD. MED. 670 (1994); Chris Feudtner & Dimitri A. Christakis, *Making the Rounds: The Ethical Development of Medical Students in the Context of Clinical Rotations*, 24 HASTINGS CENTER REP., Jan.-Feb. 1994, at 6.

470. See Charon & Fox, *supra* note 466, at 767.

The students are right to be concerned. Medical training, which includes medical school and the ever-lengthening residency, is a demanding, exhausting, unforgiving experience.<sup>471</sup> Although physicians gain technical skills, intellectual rigor, and self-discipline through this process, they often lose empathy and compassion for their patients.<sup>472</sup> Empathy is rarely taught or nurtured in medical training; it is neglected in favor of scientific reasoning and clinical detachment.<sup>473</sup> Although a few schools and training programs have recently begun to address this problem by developing methods of teaching empathy and communication skills,<sup>474</sup> they can do little to combat the fact that medicine as a profession does not hold as core values empathy or understanding for the patient as a person.<sup>475</sup>

This fact is underscored in a book, entitled *The Nature of Suffering and the Goals of Medicine*,<sup>476</sup> in which Dr. Eric Cassell explains why attempts to train doctors to have more concern for their patients have generally failed. He notes that the intellectual basis of modern medicine is scientific disease theory and that patients, as persons, simply have no place within this intellectual framework.<sup>477</sup> In

471. The popular and sociological literature are replete with first-hand accounts of the cynicism and patient indifference engendered by medical training. See ZUSSMAN, *supra* note 407, at 47 (describing the various first-person accounts of the medical socialization experience); see also Elisabeth Rosenthal, *How Doctors Learn to Think They're Doctors*, N.Y. TIMES, Nov. 28, 1995, § 4, at 1 ("Some doctors say the rigors of training actually squelched their humanity, by forcing them to operate in a high-stress atmosphere where compassion, patience and giving are not high priorities.").

472. Empathy is the capacity to understand and be sensitive to the feelings, thoughts, and experiences of another even when those thoughts or feelings are not explicitly communicated. See WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 407 (1991). In the medical setting, an empathetic clinician understands the meaning of the disease for the patient. See Jeanne Levasseur & David R. Vance, *Doctors, Nurses, and Empathy*, in EMPATHY AND THE PRACTICE OF MEDICINE, 76, 83 (Howard M. Spiro et al. eds., 1993).

473. See Howard M. Spiro, *What Is Empathy and Can It Be Taught?*, in EMPATHY AND THE PRACTICE OF MEDICINE, 7, 8-9 (Howard M. Spiro et al. eds., 1993).

474. See, e.g., Lisa Belkin, *In Lessons on Empathy, Doctors Become Patients*, N.Y. TIMES, June 4, 1992, at A1; Donna Greene, *Teaching Future Doctors the Art of Caring*, N.Y. TIMES, July 2, 1995, § 13WC, at 3; Michael T. Kaufman, *About New York; Teaching Compassion in Theater of Death*, N.Y. TIMES, Nov. 28, 1992, § 1, at 23; Cheryl P. Weinstock, *Adding a Personal Touch to Medicine*, N.Y. TIMES, May 2, 1993, § 13LI, at 4.

475. See Levasseur & Vance, *supra* note 472, at 78.

476. ERIC J. CASSELL, *THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE* 138 (1991).

477. See *id.* In one study done during the 1970s, medical students were videotaped while performing clinical interviews of patients. The researchers found that first-year students listened to the story of illness as recounted by the patient while third-year students worked to write the story of disease. See Stanley J. Reiser, *Science, Pedagogy, and the Transformation of Empathy in Medicine*, in EMPATHY AND THE PRACTICE OF MEDICINE 121, 128-29 (Howard M. Spiro et al. eds., 1993).

many ways, the individual is irrelevant; it is the disease that requires classification and treatment. Given this fundamental intellectual framework, it should come as no surprise that physicians exhibit very little understanding of human suffering.<sup>478</sup> Suffering occurs when there is a threat to the intactness of the person.<sup>479</sup> It follows, therefore, that to recognize and understand human suffering requires a view of the individual as a complex being with a past, cultural and societal roles, associations and relationships, a body and an unconscious mind, a perceived future, all of which are subject to loss and can lead to suffering.<sup>480</sup> Because suffering does not fit easily into the disease model of medicine, it cannot be diagnosed. Because it is internal to the person, it has no common pathophysiologic origin. Because it cannot be cured by the science of medicine, physicians turn away from it and thus, from their ill and dying patients.<sup>481</sup> Some of these suffering but abandoned individuals will ask their physicians to help them to die. And thus we have come full circle.

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478. See CASSELL, *supra* note 476, at 35-37. Despite the fact that the terms are frequently used interchangeably, pain and suffering are not the same things. Physical pain can surely cause suffering, but suffering is much broader, implying a threat to the integrity of the person. See *id.* at 32-33.

479. See *id.*

480. See *id.* at 43.

481. See *id.* at 46. In fact, two recent studies tend to support the view that physicians are poorly prepared to evaluate and respond to their patients' suffering. The survey of Washington physicians that explored patient requests for physician-assisted death and physicians' responses, see *supra* notes 327-331 and accompanying text, found that persons requesting assistance frequently did so not because of intolerable pain or other physical symptoms but rather because of nonphysical concerns such as loss of control, loss of dignity, and the fear of becoming a burden and dependent on others. See Back et al., *supra* note 327, at 924. Yet physicians provided assisted death more often to patients with physical symptoms such as pain, physical discomfort, and shortness of breath. See *id.* The more common nonphysical concerns did not correlate with physician assistance at all, suggesting that physicians weigh physical symptoms more heavily in deciding whether to help a patient to die. See *id.*

Another study explored whether physicians distinguish between pain and suffering in end-of-life decisionmaking. See Frederick Y. Huang & Linda L. Emanuel, *Physician Aid in Dying and the Relief of Patients' Suffering: Physicians' Attitudes Regarding Patients' Suffering and End-of-Life Decisions*, 6 J. CLINICAL ETHICS 62 (Spring 1995). These researchers found that physician responses to hypothetical situations differed depending upon whether the hypothetical patient complained of extreme physical pain or extreme nonphysical suffering. See *id.* at 66. The physicians did not assign the same moral weight to nonphysical suffering and so considered assisted suicide or euthanasia to be less justified under those circumstances. See *id.* The authors concluded that "physicians are less likely to respect patients' autonomy when patients report extreme nonphysical suffering." *Id.* at 67.

### B. *Revisiting the Substantive Question*

Having provided some insights into the nature of the medical profession, let me now return to my thought experiment in which assisted death is provided not by physicians but by aides-in-dying.<sup>482</sup> If one were to set out *ab initio* to define the desirable characteristics for a profession that provides assisted death, what would one look for? Obviously aides-in-dying would need to be skilled in the pharmacology and techniques for bringing about a quick and painless death. These would be the minimum requirements. Aides-in-dying would need strong communication and listening skills, empathy and compassion in the face of suffering, respect for individual autonomy, a willingness to share or cede decision-making power to ill individuals, training in medical ethics and the psychosocial aspects of death and dying, and a willingness to be subjected to regulation and oversight.

If these are desirable characteristics, is it so obvious that physicians are the appropriate persons in whom to rest the legal power to assist individuals to die? I submit that the medical profession is singularly unqualified to take on this task.<sup>483</sup> It is a profession defined by power and authority, woefully undertrained in psychosocial skills, and highly resistant to outside regulation.<sup>484</sup> The ultimate irony in this

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482. See *supra* notes 340-341 and accompanying text. Dr. Steven Miles has also questioned the necessity for physician involvement in assisted death. See Steven H. Miles, *Physician-Assisted Suicide and the Profession's Gyrocompass*, 25 HASTINGS CENTER REP., May-June 1995, at 17, 18. However, he proposes that in those rare cases where assisted death is justified, control be placed within the dying individual's intimate community. See *id.* This seems to me a less responsible model for non-physician assisted death than one employing aides-in-dying. Even if one conceives of assisted death as a "sociopersonal" rather than a "medicopersonal" event, see *id.*, it still seems clear that some level of expertise is needed beyond that which friends or family could reasonably provide.

483. I should add here that I have no doubt that there are doctors who would make ideal aides-in-dying. My focus here is not on individual physicians but rather on the medical profession *qua* profession, which neither values nor trains its members in the art of caring for their patients.

484. In this regard, Professor Zussman makes a fascinating observation with regard to the medical profession's view of the law. He states:

Physicians are not concerned about specific and limited legal obligations. Instead, they are concerned with the bases of medical discretion. From this perspective, the point is not what the law says but the simple fact that it says anything at all. Even if the courts eventually permit physicians a wide range of discretion, this discretion now depends, implicitly, on the indulgence of the courts. Physicians are angry about—and often overestimate—the effects of the law on limitation of treatment. But they are not angry so much because the law limits their discretion as because the very presence of the law implies that that discretion is not theirs by right.

ZUSSMAN, *supra* note 407, at 184.

debate is that the proponents of physician-assisted death know this. In fact, they use these deficiencies in the medical profession's response to the dying—the inattention to pain control, the emphasis on cure over care, and the abandonment of patients—to argue *for* physician-assisted death. The question is “Why?” Why are supporters of individual autonomy so eager to hand power to physicians?

The answer, quite simply, is that it is politically expedient to do so. The proponents of assisted-death legislation are well aware that their success as a political matter is dependent upon their willingness to embrace the medical profession. Does anyone believe that Oregon's Death with Dignity Act would have passed if it had contained a provision creating a new aid-in-dying profession? Physicians are included in every assisted-death proposal, initiative, and constitutional argument precisely because voters, legislators, and judges cannot conceive of a responsible model of assisted death that does not provide for physician involvement. Consider, for example, a recent report exploring the extent to which nurses have assisted their patients to die.<sup>485</sup> Sixteen percent of the critical-care nurses surveyed reported that they had participated in euthanasia or active suicide at least once in their careers.<sup>486</sup> The initial responses to the report included statements that the results were shocking, problematic, concerning, and frightening for the families of dying patients.<sup>487</sup> And yet, one could argue that nurses, by virtue of their training, are a much better choice than physicians to assist patients to die. Nurses are encouraged and taught to listen to their patients and to accede to their wishes. They are trained to think of patients as individuals rather than diseases, and they are expected to show empathy and understanding for their patients' suffering. The negative response to nurse involvement clearly illustrates the community's desire to defer to physicians on this matter regardless of whether they are the proper individuals to provide assisted-death services. In other words, nurses must not assist their patients to die because nurses are not doctors.

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For a description of the ways in which the medical profession has either resisted regulation or turned it to its advantage, see PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

485. See David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 *NEW ENG. J. MED.* 1374 (1996).

486. See *id.* at 1375.

487. See Gina Kolata, *1 in 5 Nurses Tell Survey They Helped Patients Die*, *N.Y. TIMES*, May 23, 1996, at A14.

I began by focusing on the process question: In a world where assisted death is legal, is it clear that physicians are the appropriate providers of this service? I have asserted in this Article that the answer to that question is at least arguably "no," and yet I have no doubt that society would be extremely resistant to a proposal in which highly trained and skilled aides-in-dying would provide assisted death to terminally ill persons who wish to die. Our unwillingness to even imagine other possibilities tells us something about ourselves, and informs the debate over the larger substantive question of whether we as a society should support assisted death at all.

It is likely that had Jack Kevorkian done everything in exactly the same way but did not have an "M.D." after his name, no jury would have acquitted him.<sup>488</sup> The jurors sympathized with his cause and deferred to his judgment for the simple reason that he was a physician. We as a society are doing precisely the same thing when we shift responsibility for assisted death to the medical profession. We take great comfort in assigning power over assisted death to physicians because we desperately want to place responsibility for assisted death with anyone other than ourselves. What better way to do it than to turn to the medical profession where the decisions and their justifications will be hidden from our view by the veil of the physician-patient relationship?

But by placing assisted death within the province of medicine and the medical profession, we risk losing the very autonomy that assisted death is designed to effectuate. We are not entitled to the false sense of comfort and security that physician involvement in assisted death brings us. We have no business demanding that physicians respect our decision-making autonomy only to hand that power back to the profession when the exercise of autonomy becomes uncomfortable or inconvenient. We are not justified in using the medical profession in this manner, even if it is willing to be used. If we cannot face the thought of assisted death facilitated by trained aides-in-dying, then perhaps we ought to rethink the question of whether we as a society are entitled to assisted death at all. Because with individual and societal autonomy comes responsibility for our choices, our decisions, and our acts.

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488. See *supra* notes 95-99 and accompanying text.

